This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1310 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/28/2020 4:40 pm use only ] Manually prepared cost report ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[19] 19. NPR Date:
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[14] 19. NPR Date:
[15] 19. NPR Date:
[16] 19. NPR Date:
[17] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) JEANNE WICKENS
Officer or Administrator of Provider(s)

CF0/SVP

Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	69, 216	-1, 487, 064	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	o				0	6.00
9.00	HOME HEALTH AGENCY I	o	0	0		0	9. 00
10.00	RHC - CASS ST I	o		-117, 413		0	10.00
10.01	RHC - N. MANCHESTER II	o		56, 271		0	10. 01
10.02	RHC - KISSINGER III	o		53, 024		0	10. 02
200.00	Total	0	69, 216	-1, 495, 182	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/28/2020 4:40 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 10 JOHN KISSINGER DR 1.00 PO Box: 1.00 State: IN 2.00 City: WABASH Zip Code: 46992 County: WABASH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PARKVI EW WABASH 151310 99915 12/17/2001 Ν 0 3.00 HOSPITAL, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF PARKVIEW WARASH 157310 99915 N 12/17/2001 N 0 7 00 7.00 HOSPITAL SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11 00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC RURAL HEALTH CLINIC -158544 99915 05/30/2019 N Ν Ν 15.00 CASS ST Hospital-Based Health Clinic - RHC RURAL HEALTH CLINIC -158541 99915 15.01 15.01 06/05/2019 Ν Ν N. MANCHESTER Hospital-Based Health Clinic - RHC RURAL HEALTH CLINIC -158542 99915 07/24/2019 N 15.02 15.02 N Ν KISSINGER 1111 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 2 21.00 1. 00 2.00 3.00 Inpatient PPS Information 22 00 Does this facility qualify and is it currently receiving payments for N N 22 00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22 01 22 01 Did this hospital receive interim uncompensated care payments for this Ν N cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22. 02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22. 03 22.03 Ν Ν Ν adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

40. 00	or "N" for no. (see instructions)  Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					40. 00
			V	XVIII	XI X	
			1.00	2. 00	3.00	
	Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accorda	ance	N	N	N	45. 00
	with 42 CFR Section §412.320? (see instructions)					
	Is this facility eligible for additional payment exception for extraordinary circumstances		N	N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I throu	ugh				
	Pt. III.					
	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no	o.	N	N	N	47. 00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48. 00
	Teaching Hospitals					
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for $y\epsilon$		N			56. 00
	"N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR),	, MA				
	GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					
	If line 56 is yes, is this the first cost reporting period during which residents in approve					57. 00
	GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If colu					
	is "Y" did residents start training in the first month of this cost reporting period? Enter					
	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2	is				
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					
	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as					58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59. 00

PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 Provi der CCN: 15-1310 Peri od: From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/28/2020 4:40 pm NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2. 60.00 Direct GME IME Direct GME 3. 00 1.00 2.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports 61.01 ending and submitted before March 23, 2010. (see 6

61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,					61. 02		
61. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care					61. 03		
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61. 04		
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's					61. 05		
61. 06	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary					61. 06		
	care or general surgery. (see instructions)	Dragram Nama	Drogram Code	Upwai abtad IMF	Unwei abted			
		Program Name	Program code	Unwei ghted IME FTE Count	Direct GME FTE Count			
(1.10	Of the FTFe in line (1 OF enesify each new program	1.00	2. 00	3. 00	4.00	61. 10		
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME			0.00	0.00	61. 10		
61. 20	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,			0. 00	0. 00	61. 20		
	the direct GME FTE unweighted count.							
	ACA Provisions Affecting the Health Resources and Ser	avi cos Administration	(HDCA)		1.00			
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trained in this cost	reporting peri			62. 00		
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ıram. (see instruction		your hospital	0.00	62. 01		
63. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings during this co	7. (see instru	ctions)	N	63. 00		
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))			
			1. 00	2. 00	3.00			
	Section 5504 of the ACA Base Year FTE Residents in No.		This base year	is your cost r	eporting			
64. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non	y trained residents n-primary care	0.00	0.00	0. 000000	64. 00		
	resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	I non-primary care n column 3 the ratio						
WCRIF3.	2 - 16. 1. 168. 2							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/28/2020 4:40 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	Financial Systems PARKVIEW WABASH HO	Provi der CC		In Lie Period: From 01/01/2019 To 12/31/2019	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 7/28/2020 4:4	epared:	
						J pin	
	ong Term Care Hospital PPS				1.00	_	
80.00	g period? Enter	N N	80. 00 81. 00				
85. 00 86. 00	or "N" for no. on	N	85. 00 86. 00				
87.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  Is this hospital an extended neoplastic divises e care hospital	classified u	nder section		N	87. 00	
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XI X		
				1. 00	2.00		
	Fitle V and XIX Services	convices? En	tor "V" for	N	Y	90.00	
	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	Services? En	iter y ror	IN IN	ľ	90.00	
	s this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli		either in	N	N	91. 00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dua nstructions) Enter "Y" for yes or "N" for no in the applicab	al certificati	on)? (see		N	92. 00	
	Does this facility operate an ICF/IID facility for purposes o 'Y" for yes or "N" for no in the applicable column.		XIX? Enter	N	N	93. 00	
95.00	95.00   If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the						
98. 00	98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Y stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in						
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.			Y	Y	98. 01	
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calloed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98. 02	
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a criti- reimbursed 101% of inpatient services cost? Enter "Y" for yes			N	N	98. 03	
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH ro outpatient services cost? Enter "Y" for yes or "N" for no in a			N	N	98. 04	
98. 05	n column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co			Y	Y	98. 05	
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Υ	Y	98. 06	
	Rural Providers			.,		405 55	
106.00	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	od of paymen	t Y		105. 00 106. 00	
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column			N		107. 00	
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instructio	ou train I&Rs and/or IRF u	in an				
108.00	Interior for yes of Notification Colombia. (See Instruction is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		ul e? See 42	N		108. 00	
	5.13 300 troit 3412. 113(c). Litter 1 101 yes or in 101 110.	Physi cal	Occupati ona	Speech	Respi ratory		
100.00	f this begrital qualifies as a CAU as a sect provider, are	1.00	2.00	3.00	4.00	100.00	

CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							
	Physi cal	Occupati onal	Speech	Respi ratory			
	1. 00	2.00	3. 00	4. 00			
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00		
therapy services provided by outside supplier? Enter "Y"							
for yes or "N" for no for each therapy.							
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (§41	OA	N	110.00		
Demonstration) for the current cost reporting period? Enter "							
complete Worksheet E, Part A, lines 200 through 218, and Wor							
appl i cabl e.							

131.00

131.00 If this is a Medicare certified intestinal transplant center, enter the certification

date in column 1 and termination date, if applicable, in column 2.

144.00 Are provider based physicians' costs included in Worksheet A?

1.00

144. 00

	1. 00	2.00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for		145. 00	
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is			
no, does the dialysis facility include Medicare utilization for this cost reporting			
period? Enter "Y" for yes or "N" for no in column 2.			
146.00 Has the cost allocation methodology changed from the previously filed cost report?		146. 00	
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If			
yes, enter the approval date (mm/dd/yyyy) in column 2.			
		1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147. 00
148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148. 00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for r	10.	N	149. 00
Part A Part B	Title V	Title XIX	
1. 00 2. 00	3. 00	4. 00	
Does this facility contain a provider that qualifies for an exemption from the applicat	on of the lowe	er of costs	

or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν 155 00 156.00 Subprovi der - IPF Ν Ν Ν 156. 00 Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00

165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code CBSA Name County State 3.00 5.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

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

167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)

168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)

Beginning Ending

	1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2 (see instructions)			

Multicampus

Ν

N

Ν

N

18.00

19.00

totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date

If line 16 or 17 is yes, were adjustments made to PS&R

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

in columns 2 and 4. (see instructions)

cost report? If yes, see instructions.

information? If yes, see instructions.

18.00

19.00

Heal th	Financial Systems PARKVIEW WABASH I	HOSPITAL, INC.		In Lie	u of Form CMS	-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	Provider CCN: 15-1310 PFT		Worksheet S- Part II Date/Time Pr 7/28/2020 4:	epared:			
		Descr	i pti on	Y/N	Y/N				
20.00	LE Line 1/ on 17 in one many adjustments and to DCOD		0	1.00	3. 00	20.00			
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			
	Troper t data for other become the time other day detimented	Y/N	Date	Y/N	Date				
		1.00	2. 00	3. 00	4. 00				
21. 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	PT CHILDRENS H	HOSPI TALS)						
00.00	Capi tal Related Cost								
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sale mado dur	ng the cost	N N	22. 00 23. 00			
23.00	reporting period? If yes, see instructions.	uue to apprais	sais illaue uui	riig the cost	IN	23.00			
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00			
25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see	N	25. 00			
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit	N	27. 00			
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	reporting	N	28. 00					
29. 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	N	29. 00						
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.	N	30. 00						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	N	31. 00						
22.00	Purchased Services	atnostusi	N	22.00					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	itractuai	įΝ	32. 00					
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	N	33. 00			
	Provi der-Based Physi ci ans								
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physicians?	Υ	34. 00			
35. 00	If line 34 is yes, were there new agreements or amended exilohysicians during the cost reporting period? If yes, see in		nts with the	orovi der-based	Υ	35. 00			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Y/N	Date				
	lu occi o			1. 00	2. 00				
26 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00			
36. 00 37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y		37. 00			
07.00	If yes, see instructions.	opar ou by the	nome office.			07.00			
38. 00	If line 36 is yes, was the fiscal year end of the home off			N		38. 00			
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.			. N		39. 00			
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00			
	Cost Poport Propagar Contact Information	1.	00	2.	00				
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00			
42. 00		PARKVIEW HEALT	TH SYSTEM, INC	2.		42. 00			
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2603738406		ERI C. NI CKESON@F	PARKVI EW. COM	43. 00			

Health Financial Systems PARKVIEW WABASH			HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
HOSPITAL A	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi	der CCN: 15-1310	Peri		Worksheet S-	2	
					To	1 01/01/2019 12/31/2019	Date/Time Pr		
							7/28/2020 4:	40 pili	
				3. 00					
Cos	t Report Preparer Contact Information				•				
41. 00 Ent	er the first name, last name and the t	itle/position	DI RECTOR,	REIMBURSEMENT				41. 00	
hel	d by the cost report preparer in colum	ns 1, 2, and 3,							
res	specti vel y.								
42. 00 Ent	er the employer/company name of the co	st report						42. 00	
pre	eparer.								
	er the telephone number and email addr							43. 00	
rep	oort preparer in columns 1 and 2, respe	cti vel y.						1	

 
 Heal th Financial
 Systems
 PARKVIEW V

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-1310

				To	12/31/2019	Date/Time Prep	
						7/28/2020 4:40 I/P Days / 0/P	) piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. of beas	Avai I abl e	CALL HOULS	II LIE V	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00			82, 392. 00	0.00	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		18	6, 570	82, 392. 00	0	7. 00
	beds) (see instructions)						
8.00	I NTENSI VE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00		/ 570	00 000 00	0	13.00
14.00	Total (see instructions)		18	6, 570	82, 392. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00 17. 00	SUBPROVIDER - I PF						16. 00 17. 00
18. 00	SUBPROVI DER - I RF SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				ŭ	23. 00
24. 00	HOSPI CE	116. 00	0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.00					25. 00
26. 00	RHC - CASS ST	88. 00				o	26. 00
26. 01	RHC - N. MANCHESTER	88. 01				0	26. 01
26. 02	RHC - KISSINGER	88. 02				0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		18				27.00
28. 00	Observation Bed Days					0	28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

 Heal th Financial
 Systems
 PARKVIEW V

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-1310

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm

Component   Component   Component   Title XVIII   Title XVIX   Total Interns   Employees On							7/28/2020 4:4	O pm
New York				3 / O/P Visits	/ Trips	Full Time Equivalents		
1.00		Component	Title XVIII	Title XIX				
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LOP room available beds)   1,154   91   2,00   3.00   4.00   4.00   4.00   4.00   4.01   4.00			6.00	7. 00	8. 00	9. 00	10.00	
3.00   HMO IPF Subprovi der	1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 327	85	3, 273			1.00
4. 00	2.00	HMO and other (see instructions)	1, 154	91				2. 00
5.00	3.00	HMO I PF Subprovi der	0	0				3. 00
6. 00   Hospital Adults all Peds. (exclude observation beds) (see Instructions)   1, 327   85   3, 274     6. 00   7. 00   1   7. 00   7	4.00	HMO IRF Subprovider	0	0				4. 00
7. 00   Total Adults and Peds. (exclude observation body) (see instructions)   1,327   85   3,274   85   8.00   1NTENSI VE CARE UNIT   9,000   10.00   BURN INTENSI VE CARE UNIT   10.00   1	5.00		0	o	C			5. 00
beds) (see instructions)   8	6.00	Hospital Adults & Peds. Swing Bed NF		0	1			6. 00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 15. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 OWNESING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 20. 00 HOME HEALTH AGENCY 21. 00 OWNE HEALTH AGENCY 22. 00 HOME COMMINICATED TO SINGLE STREET OR SINGLE STREET STREET SINGLE SINGLE STREET SINGLE STREET SINGLE STREET SINGLE STREET SINGLE SINGLE STREET SINGLE SINGLE STREET SINGLE STREET SINGLE STREET SINGLE STREET SINGLE SINGLE STREET SINGLE S		beds) (see instructions)	1, 327	85	3, 274			
10.00   BURN INTENSIVE CARE UNIT   10.00   11.00   1								
11.00   SURGI CAL INTENSIVE CARE UNIT								1
12. 00 0 THER SPECIAL CARE (SPECIFY) 13. 00 14. 00 170 total (see instructions) 1, 327 173 3, 433 0. 00 171. 50 14. 00 15. 00 16. 00 18. 00 19. 00 18. 00 18. 00 19. 00 18. 00 18. 00 19. 00 18. 00 18. 00 19. 00 18. 00 18. 00 19. 00 18. 00 18. 00 19. 00 18. 00 19								
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 0 0 0 0 0 0 0 0 15. 00 CAH visits 15. 00 CAH visits 0 0 0 0 0 0 0 0 0 0 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSIN OF FACILITY 19. 00 ON NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
14. 00 Total (see instructions) 15. 00 CAH visits 0 0 0 0 0 15. 00 15. 00 CAH visits 0 0 0 0 0 15. 00 15. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RHC - CMHC 27. 00 THC - CMHC 28. 00 CMHC - ISSI NGER 28. 01 RHC - N. MANCHESTER 29. 02 MANCHESTER 20. 03 MANCHESTER 20. 04 MC - CMHC 20. 05 MC - CMHC 20. 06 MC - CMHC 20. 07 MC - CMHC 20. 08 MC - CMSS ST 20. 08 MC - CMSC 20. 09 MANCHESTER 20. 09 MANCHESTER 20. 00 MC - M				0.0	450			
15. 00 CAH visits			1 227				171 50	
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER   IRF 18. 00 ON MURSI NG FACI LI TY   19. 00 ON		1 '			•		171.50	
17. 00   SUBPROVI DER - I RF   17. 00   18. 00   SUBPROVI DER   18. 00   19. 00   SUBLED NURSI NG FACILITY   19. 00   20			U	U	C			
18. 00   SUBPROVI DER   18. 00   19. 00   20. 00   20. 00   21. 00   21. 00   21. 00   22. 00   22. 00   40ME HEALTH AGENCY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
19. 00								
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   23.00   24.00   25.00   26.00   2								
21.00   OTHER LONG TERM CARE   20   HOME HEALTH AGENCY   0   0   0   0   0   0   0   0   0								1
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RHC - CASS ST 26. 01 RHC - N. MANCHESTER 26. 02 RHC - KISSINGER 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
23. 00			0	0	0	0.00	0.00	
24. 00 HOSPICE			J	U	C	0.00	0.00	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RHC - CASS ST			0	0	0	0.00	0.00	1
25. 00 CMHC - CMHC 26. 00 RHC - CASS ST 26. 01 RHC - CASS ST 26. 01 RHC - N. MANCHESTER 26. 02 RHC - KISSINGER 26. 02 FEDERALLY QUALIFIED HEALTH CENTER 26. 05 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 31. 00 Labor & delivery days (see instructions) 31. 00 Utypatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 00 26. 00 1, 781 1, 785 1, 71 25, 00 0, 0				O .	-		0.00	
26. 00 RHC - CASS ST								
26. 01 RHC - N. MANCHESTER 1, 637 58 7, 165 0.00 7. 91 26. 01 26. 02 RHC - KISSINGER 1, 006 44 3, 310 0.00 3. 44 26. 02 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 0 192. 74 27. 00 28. 00 Observation Bed Days 86 1, 434 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) Employee discount days - IRF 0 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 0 6 6 67 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 9 17. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18			1 781	186	12 220	0.00	9.89	
26. 02 RHC - KISSINGER 1,006 44 3,310 0.00 3.44 26.02 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 192.74 27.00 28.00 Observation Bed Days 86 1,434 29.00 Ambul ance Trips 0 Employee discount days (see instruction) Employee discount days - IRF 0 Employee discount days (see instructions) 31.00 Employee discount days (see instructions) 0 6 67 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 84 1,006 44 3,310 0.00 0 0 0.00 26.25 0.00 0.00 192.74 27.00 192.74 27.00 192.74					·			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 192. 74 27. 00 28. 00 Observation Bed Days 86 1, 434 28. 00 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) Employee discount days - IRF 0 31. 00 29.					·			
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days - IRF 20.00 Labor & delivery days (see instructions) 31.00 End ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days  0.00 192.74 27.00 28.00 29.00 29.00 29.00 30.00 6 67 31.00 32.00 32.01 33.00					·			
28.00   Observation Bed Days   28.00   29.00   Ambulance Trips   0   29.00   30.00   Employee discount days (see instruction)   31.00   Employee discount days - IRF   0   31.00   32.00   Labor & delivery days (see instructions)   0   6   67   32.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   1.00			Š	Ŭ.	· ·			
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 11 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 6 67 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01  TCH non-covered days 0 33.00				86	1. 434			
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 30.00 6 67 32.00 32.01			0		.,			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 Significant days (see instructions) 32.01 Significant days (see instructions) 33.00 Significant days (see instructions) 31.00 Significant days (see instructions) 32.01 Significant days (see instructions) 33.00 Significant days (see instructions) 33.00 Significant days (see instructions)			٦		11			
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 6 67 0 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  0 32.01			n	6	-			
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00			Ĭ	Ĭ				
33.00 LTCH non-covered days 0 33.00					· ·			
	33.00		0					33.00
	33. 01		0					33. 01

Provider CCN: 15-1310

				10	0 12/31/2019	7/28/2020 4:4	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(	0 493	39	1, 275	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			404	7.4		0.00
2.00	HMO and other (see instructions)			404	74		2.00
3.00	HMO IPF Subprovider				0		3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider				0		5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF						6.00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00		493	39	1, 275	
15. 00	CAH visits			1	-	.,	15. 00
16. 00	SUBPROVIDER - IPF						16, 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RHC - CASS ST	0. 00					26. 00
26. 01	RHC - N. MANCHESTER	0. 00					26. 01
26. 02	RHC - KISSINGER	0. 00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)			0			33.00
	LTCH non-covered days LTCH site neutral days and discharges						33.00
33.01	LIGHT SI LE HEULT AT LAYS AND UI SCHALLYES			ı		I	J 33. UI

Health Financial System	ns PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS	-2552-1
HOSPITAL-BASED RHC/FQH	C STATISTICAL DATA		Provider C	CN: 15-1310	Peri od:	Worksheet S-	8
			Component	CCN: 15-8544	From 01/01/2019 To 12/31/2019		
					RHC I	7/28/2020 4:	40 pili
					1		
					1.	00	
	and Identification				1.55 N 0.400 OT		
1.00 Street			Ci	ty	1655 N CASS ST State	ZIP Code	1.0
				00	2. 00	3. 00	
2.00 City, State, ZIF	Code, County		WABASH			46992	2.0
					<u>.</u>		
	50110 011111 5 1	"D" C				1. 00	
3. 00 HOSPI TAL-BASED I	FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u		n+ Award		O 3. C
					nt Award 1.00	Date 2.00	
Source of Federa	al Funds			1	1.00	2.00	
	n Center (Section 330(d), PHS	Act)					4.0
	Center (Section 329(d), PHS Ad						5.0
,	for the Homeless (Section 340	J(d), PHS Act)					6.0
7.00 Appal achi an Regi 3.00 Look-Ali kes	onal Commission						7.0
9. 00 OTHER (SPECIFY)							9. 0
				1			
					1. 00	2. 00	
yes or "N" for m	ity operate as other than a ho no in column 1. If yes, indica scripts of line 11 the type of	ate number of d	other operation	ns in column	N		0 10.0
indui 3. y		Sun	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 CLINIC	of operations (1)		I	08: 00	17: 00	08: 00	11. 0
1.00  CLINIC				08.00	17.00	08.00	11.0
					1. 00	2. 00	
	ed an approval for an exception				N		12.0
30.8? Enter "Y"	lidated cost report as defined for yes or "N" for no in colu ders included in this report.	umn 1. If yes,	enter in colum	nn 2 the	N		0 13.0
Tidiliber's berow.				Prov	ider name	CCN number	
					1. 00	2. 00	
4.00 RHC/FQHC name, (	CCN number						14.0
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
5.00 Have you provide	ed all or substantially all	1.00	2.00	3.00	4.00	5.00	15. 0
	"Y" for yes or "N" for no in						10.0
column 1. If yes	s, enter in columns 2, 3 and						
	program visits performed by						
	nts for titles V, XVIII, and ole. Enter in column 5 the						
	visits for this provider.						
(see instruction	•						
				unty			
00 0:+0 0+-+- 71	2 Code County			00			2.0
.00 City, State, ZII	- code, county	Tuesday	WABASH Wedn	esday	Thur	sday	2.0
		to	from	to	from	to	
		6. 00	7. 00	8.00	9. 00	10.00	
	of operations (1)						
11. 00 CLINIC		17: 00	08: 00	17: 00	08: 00	17: 00	11

Health Financial Systems P.	ARKVIEW WABASH I	HOSPITAL, INC.		In Lieu of Form CMS-2552-			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1310	Peri od:	Worksheet S-8		
				From 01/01/2019			
		Component	CCN: 15-8544	To 12/31/2019			
					7/28/2020 4:4	O pm	
				RHC I			
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	17: 00				11. 00	

alth Financial Systems SPITAL-BASED RHC/FQHC STATISTICAL DATA	PARKVI EW WABASH		CCN: 15-1310	Peri od:	eu of Form CM Worksheet	
		Component	CCN: 15-8541	From 01/01/201 To 12/31/201		
				RHC II	772672020	4. 40 L
		<u> </u>				
				1	. 00	
Clinic Address and Identification OStreet				1104 N. WAYNE	ST.	<b>-</b>
50   Street		C	i ty	State	ZIP Code	
			. 00	2. 00	3. 00	
OO City, State, ZIP Code, County		NORTH MANCHES	ΓER	I	N 46962	-   :
					1.00	
0 HOSPITAL-BASED FQHCs ONLY: Designation -	Enter "R" for rura	al or "U" for	urban		1.00	0 :
			Grai	nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds Community Health Center (Section 330(d),	DUC Ac+)		T		T	
Migrant Health Center (Section 330(d),						
O Health Services for the Homeless (Section						
O Appalachian Regional Commission						
O Look-Alikes O OTHER (SPECIFY)						
U JUHIER (SPECIFT)						
				1. 00	2.00	
OD Does this facility operate as other than yes or "N" for no in column 1. If yes, i 2. (Enter in subscripts of line 11 the ty hours.)	ndicate number of	other operation	ns in column	N		0 10
, noun or y	Sur	nday	N	londay	Tuesday	
	from	to	from	to	from	
Facility house of energtions (1)	1.00	2.00	3.00	4. 00	5. 00	
Facility hours of operations (1)  OU CLINIC			08: 00	17: 00	08: 00	1
		•				
20 14				1.00	2. 00	
00 Have you received an approval for an exc 00 Is this a consolidated cost report as de 30.8? Enter "Y" for yes or "N" for no in number of providers included in this rep numbers below.	efined in CMS Pub. n column 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N		0 13
				ider name	CCN number	r
OO DUC/FOUC name CCN number				1. 00	2. 00	1
00 RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visi	ts 1
	1.00	2.00	3.00	4.00	5. 00	
00 Have you provided all or substantially a GME cost? Enter "Y" for yes or "N" for rolumn 1. If yes, enter in columns 2, 3 4 the number of program visits performed Intern & Residents for titles V, XVIII,	no in and I by					1!
XIX, as applicable. Enter in column 5 th number of total visits for this provider (see instructions)						
			unty			
O City, State, ZIP Code, County		WABASH 4.	. 00			
o jointy, otato, ziii oode, codiiity	Tuesday		iesday	Thu	ırsday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)			•			

Health Financial Systems PA	ARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1310	Peri od:	Worksheet S-8	
				From 01/01/2019		
		Component	CCN: 15-8541	To 12/31/2019		
					7/28/2020 4:4	O pm
				RHC II		
	Fric	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

	Financial Systems PA AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1310	Peri od:	Worksheet S	S-8	
			Component	CCN: 15-8542	From 01/01/2019 To 12/31/2019			
					RHC III	772072020 -	7. 40	Pili
			<u>.</u>					
					1.	. 00	_	
	Clinic Address and Identification Street				8 JOHN KISSING	CED DD	_	1.
00	Street		Ci	ty	State	ZIP Code	-	
				00	2. 00	3.00		
00	City, State, ZIP Code, County	V	VABASH		1 N	46992		2
						1.00		
0	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	r "R" for rural	or "II" for i	ırhan		1.00	0	3
	THOSE TENE-DASED TRICS ONET. Designation - Ente	i k toi turai	01 0 101 0		nt Award	Date		
					1. 00	2.00		
	Source of Federal Funds							
0	Community Health Center (Section 330(d), PHS							4
0	Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340							5 6
0	Appal achi an Regional Commission	(a), IIIS ACL)						7
0	Look-Alikes							8
0	OTHER (SPECIFY)							9
					4.00	0.00		
	Does this facility operate as other than a ho	enital based Di	JC or EOUC2 Er	tor "V" for	1. 00 N	2. 00	0	10
00	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of o	ther operation	s in column	N			10
	indui di )	Suno	lay	M	onday	Tuesday		
		from	to	from	to	from		
		1.00	2.00	3.00	4. 00	5. 00		
	E 1111 (4)	1.00	2.00	3.00	4.00	3.00	_	
00	Facility hours of operations (1)	1.00	2. 00					11
00	Facility hours of operations (1)	1.00	2.00	08: 00	17: 00	08: 00		11
00		1.00	2.00					11
00	CLINIC  Have you received an approval for an exception	n to the produc	ctivity standa	08: 00 ard?	17: 00 1. 00 N	08: 00		12
00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	on to the produc lin CMS Pub. 10 mmn 1. If yes, 6	ctivity standa 00-04, chapter enter in colum	08:00  ard?  -9, section  an 2 the	17: 00	08: 00		12
00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	on to the produc lin CMS Pub. 10 mmn 1. If yes, 6	ctivity standa 00-04, chapter enter in colum	08:00  ord? 9, section 10 2 the lers and	17: 00 1. 00 N N	08: 00	0	12
00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	on to the produc lin CMS Pub. 10 mmn 1. If yes, 6	ctivity standa 00-04, chapter enter in colum	08:00  ord? 9, section 10 2 the 10 lers and 11 Provi	17: 00 1. 00 N	08: 00	0	12
00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	on to the produc lin CMS Pub. 10 mn 1. If yes, 6 List the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the 10 lers and 11 Provi	17:00 1.00 N N	08: 00 2. 00 CCN number 2. 00	0	12
00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below.	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12
00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. In numbers below.  RHC/FQHC name, CCN number	on to the produc lin CMS Pub. 10 mn 1. If yes, 6 List the names	ctivity standa 00-04, chapter enter in colum of all provic	one of the lers and one of the lers are one of	17:00 1.00 N N der name 1.00	08: 00 2. 00 CCN number 2. 00	0	12 13
00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. In numbers below.  RHC/FOHC name, CCN number  Have you provided all or substantially all	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column number of providers included in this report. In numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In numbers below.  RHC/FOHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception and the state of the st	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception and the state of the st	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception and the state of the st	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00	Have you received an approval for an exception and the state of the st	on to the production CMS Pub. 10 mm 1. If yes, callist the names	ctivity standa 00-04, chapter enter in colum of all provic V 2.00	08:00  ord? 9, section 10 2 the Iders and  Provi	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In the second sec	on to the production to the production CMS Pub. 10 mmn 1. If yes, of List the names  Y/N 1.00	ctivity standa 00-04, chapter enter in colum of all provic  V 2.00	08:00  ard? 9, section n 2 the lers and  Provi  XVIII 3.00	17: 00 1. 00 N N der name 1. 00	08: 00  2. 00  CCN number 2. 00  Total Visit	0	12 13
00 00 00	Have you received an approval for an exception and the state of the st	on to the production to the production CMS Pub. 10 Imn 1. If yes, of List the names  Y/N 1.00	ctivity standa DO-04, chapter enter in colum of all provic  V 2.00  Cou 4. WABASH	08:00  ard? 9, section n 2 the ders and  Provi  XVIII 3.00	17: 00  1. 00  N  N  N  A  A  A  A  A  A  A  A  A  A	08: 00  2. 00  CCN number 2. 00  Total Visit 5. 00	0	12 13
00 00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In the second sec	on to the production to the production CMS Pub. 10 mm 1. If yes, of List the names  Y/N 1.00	ctivity standa DO-04, chapter enter in colum of all provic  V 2.00  Cou 4. VABASH Wedn	08:00  ard? 9, section 10:2 the 10:3 and  Provi  XVIII 3.00  anty 00  esday	17: 00  1. 00  N N N  der name 1. 00  XIX 4. 00	08: 00  2. 00  CCN number 2. 00  Total Visit 5. 00	0	12 13 14 15
00 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. In the second sec	on to the production to the production CMS Pub. 10 Imn 1. If yes, of List the names  Y/N 1.00	ctivity standa DO-04, chapter enter in colum of all provic  V 2.00  Cou 4. WABASH	08:00  ard? 9, section n 2 the ders and  Provi  XVIII 3.00	17: 00  1. 00  N  N  N  A  A  A  A  A  A  A  A  A  A	08: 00  2. 00  CCN number 2. 00  Total Visit 5. 00	0	11.

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1310	Peri od:	Worksheet S-8		
				From 01/01/2019			
		Component	CCN: 15-8542	To 12/31/2019			
					7/28/2020 4:4	0 pm	
				RHC III			
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	17: 00				11. 00	

	AL UNCOMPENSATED AND INDIGENT CARE DATA Prov	/ider CCN: 15-1310		eri od:	Worksheet S-10	0
				om 01/01/2019	Data/Time Dray	
			To	12/31/2019	Date/Time Prep 7/28/2020 4:40	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	d by line 202 col	lumn 8	3)	0. 276998	1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid				1, 190, 891	2.
00 00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental;	novmonts from Nov	di coi c	10	N N	3. 4.
00	If line 4 is no, then enter DSH and/or supplemental payments from N		urcarc	. :	0	5.
00	Medicaid charges	mear ear a			11, 224, 575	6.
00	Medicaid cost (line 1 times line 6)				3, 109, 185	7.
00	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum of	lines	3 2 and 5; if	1, 918, 294	8.
	< zero then enter zero)					
00	Children's Health Insurance Program (CHIP) (see instructions for each the children is the children in the children is the children in the children in the children is the children in the children in the children in the children is the children in the chil	ach line)			F4 447	
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				51, 417 320, 213	9.
. 00	Stand-alone CHIP cost (line 1 times line 10)		88, 698			
. 00	Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus line 9	9: if	< zero then	37, 281	
	enter zero)		.,		2., 20.	
	Other state or local government indigent care program (see instruct					
. 00	Net revenue from state or local indigent care program (Not included				1, 398, 314	
. 00	Charges for patients covered under state or local indigent care pro	ogram (Not includ	ded ir	ilines 6 or	13, 078, 134	14
. 00	10)   State or local indigent care program cost (line 1 times line 14)				3, 622, 617	15
. 00	Difference between net revenue and costs for state or local indiger	nt care program	(Line	15 minus line	2, 224, 303	
	I a second secon					10
	13; if < zero then enter zero)					10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP ar					10.
'. 00		nd state/local in			ns (see	17.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP arinstructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	nd state/local ir	ndi ger	nt care program	ns (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP arinstructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitatel unreimbursed cost for Medicaid, CHIP and state and local income.	nd state/local ir	ndi ger	nt care program	ns (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP arinstructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi	nd state/local ir	ndi ger	nt care program	ns (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP arinstructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitatel unreimbursed cost for Medicaid, CHIP and state and local income.	nd state/local in ng charity care ital operations digent care progr	ndi ger rams ( red ts	it care program (sum of lines Insured patients	0 0 4,179,878 Total (col. 1 + col. 2)	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local including and 16)	nd state/local in ng charity care ital operations digent care progr	ndi ger rams ( red ts	nt care program (sum of lines	0 0 4,179,878 Total (col. 1	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies, 12 and 16)  Uncompensated Care (see instructions for each line)	nd state/local in ng charity care ital operations digent care progr  Uninsur patien 1.00	rams (	(sum of lines Insured patients 2.00	0 0 4,179,878 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local incompanies, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility	nd state/local in ng charity care ital operations digent care progr  Uninsur patien 1.00	ndi ger rams ( red ts	it care program (sum of lines Insured patients	0 0 4,179,878 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies, 12 and 16)  Uncompensated Care (see instructions for each line)	nd state/local in ng charity care ital operations digent care progration uninsurpatien 1.00	rams (	(sum of lines Insured patients 2.00	0 0 4,179,878 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilities (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)	nd state/local in ng charity care ital operations digent care progrations   Uninsurpation   1.00  ty	rams (red ts 0, 271 6, 420	(sum of lines Insured patients 2.00 889,495	0 0 4,179,878 Total (col. 1 + col. 2) 3.00 3,439,766 1,595,915	17. 18. 19. 20.
0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilities (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off	nd state/local in ng charity care ital operations digent care progrations   Uninsurpation   1.00  ty	rams (red ts	(sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3. 00 3, 439, 766	17. 18. 19. 20.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of the entire facilities of the entire facilities of the entire facilities of the patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care.	nd state/local in ng charity care ital operations digent care progration 1.00  Uninsur patien 1.00  ty 2,550 (see 700 as 45	rams (red ts 0, 271 6, 420	(sum of lines Insured patients 2.00 889,495	Total (col. 1 + col. 2) 3.00 3,439,766 1,595,915	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompanies. The support of the entire facilities of the entire facilities of the patients approved for charity care and uninsured discounts instructions.  Payments received from patients for amounts previously written off charity care.	nd state/local in ng charity care ital operations digent care progration 1.00  Uninsur patien 1.00  ty 2,550 (see 700 as 45	rams (red ts 0, 271 6, 420 8, 436	(sum of lines Insured patients 2.00 889,495 889,495 5,141	Total (col. 1 + col. 2) 3. 00 3, 439, 766 1, 595, 915 53, 577 1, 542, 338	17. 18. 19. 20. 21.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)	nd state/local in ng charity care ital operations digent care progrations digent care progration 1.00  ty 2,550  (see 700  as 465	rams (red ts 0, 271 6, 420 8, 436 7, 984	(sum of lines Insured patients 2.00 889,495 889,495 5,141 884,354	Total (col. 1 + col. 2) 3. 00 3, 439, 766 1, 595, 915 53, 577 1, 542, 338	17. 18. 19. 20. 21. 22. 23.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient de imposed on patients covered by Medicaid or other indigent care proposed.	nd state/local in ng charity care ital operations digent care progration 1.00  ty 2,550 (see 700 as 4:05)  ays beyond a lenggram?	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of	Sum of lines Insured patients 2.00 889,495 5,141 884,354	Total (col. 1 + col. 2) 3.00 3,439,766 1,595,915 53,577 1,542,338	17. 18. 19. 20. 21. 22. 23.
. 00 . 00 . 00 . 00 . 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilia (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)	nd state/local in ng charity care ital operations digent care progration 1.00  ty 2,550 (see 700 as 4:05)  ays beyond a lenggram?	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of	Sum of lines Insured patients 2.00 889,495 5,141 884,354	Total (col. 1 + col. 2) 3. 00 3, 439, 766 1, 595, 915 53, 577 1, 542, 338	17 18 19 20 21 22 23
0.00 0.00 0.00 0.00 0.00 0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care proposed in the charges for patient days beyond the interpretations.	digent care progrations  Uninsurpation 1.00  ty 2,556  (see 70  as 46  ays beyond a lenggram?  ndigent care program?	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of	Sum of lines Insured patients 2.00 889,495 5,141 884,354	Total (col. 1 + col. 2) 3.00 3,439,766 1,595,915 53,577 1,542,338	20. 21. 22. 23. 24.
3. 00 0. 00 0. 00 0. 00 1. 00 1. 00 1. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care proglif line 24 is yes, enter the charges for patient days beyond the instay limit	nd state/local in ng charity care ital operations digent care progrations digent care progration 1.00  ty 2,556  (see 706  as 46  ays beyond a lenggram? ndigent care progrations)	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of	Sum of lines Insured patients 2.00 889,495 5,141 884,354	Total (col. 1 + col. 2) 3. 00 3, 439, 766 1, 595, 915 53, 577 1, 542, 338 1. 00 N	20. 21. 22. 23. 24. 25.
3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 5. 00 6. 00 7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local income as a second state and local income as a second state and local incompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facilia (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient dai imposed on patients covered by Medicaid or other indigent care proulf line 24 is yes, enter the charges for patient days beyond the instay limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare allowable bad debts for the entire hospital complex (see instructions)	nd state/local in ng charity care ital operations digent care progration 1.00  ty 2,550  as 40  ays beyond a lengram? ndigent care program? ctions) ee instructions)	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of	Sum of lines Insured patients 2.00 889,495 5,141 884,354	Total (col. 1 + col. 2) 3.00 3,439,766 1,595,915 53,577 1,542,338 1.00 N 0 4,092,852 590,215 908,023	20. 21. 22. 23. 24. 25. 26. 27. 27.
33. 00 3. 00 3. 00 3. 00 3. 00 4. 00 5. 00 7. 00 7. 01 33. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP ar instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospitotal unreimbursed cost for Medicaid, CHIP and state and local incompensated Care (see instructions for each line)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care programment of the programment of the charges for patient days beyond the instay limit total bad debt expense for the entire hospital complex (see instructions)  Total bad debt expense for the entire hospital complex (see instructions)	nd state/local in ng charity care ital operations digent care progration 1.00  ty 2,550 as 4: 65  ays beyond a lenggram? ndigent care progrations) ee instructions)	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of gram's	Sum of lines Insured patients 2.00 889,495 5,141 884,354	3, 439, 766 1, 595, 915 53, 577 1, 542, 338 1. 00 4, 092, 852 590, 215 908, 023 3, 184, 829	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
5. 00 6. 00 7. 00 7. 01 3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care proposed in the control of the complex (see instructions)  Total bad debt expense for the entire hospital complex (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	nd state/local in ng charity care ital operations digent care progration 1.00  ty 2,550 as 4: 65  ays beyond a lenggram? ndigent care progrations) ee instructions)	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of gram's	Sum of lines Insured patients 2.00 889,495 5,141 884,354	3, 439, 766 1, 595, 915 53, 577 1, 542, 338 1. 00 0 4, 092, 852 590, 215 908, 023 3, 184, 829 1, 199, 999	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP are instructions for each line)  Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facility (see instructions)  Cost of patients approved for charity care and uninsured discounts instructions)  Payments received from patients for amounts previously written off charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care proposed in the control of the complex (see instructions)  Total bad debt expense for the entire hospital complex (see instructions)  Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	digent care progrations digent care progration 1.00  ty 2,556  as 4:  ays beyond a lenggram?  ndigent care program?  ctions)  ee instructions)  ee (see instructions)	rams (red ts 0, 271 6, 420 8, 436 7, 984 gth of gram's	Sum of lines Insured patients 2.00 889,495 5,141 884,354	3, 439, 766 1, 595, 915 53, 577 1, 542, 338 1. 00 4, 092, 852 590, 215 908, 023 3, 184, 829	20 21 22 23 24 25 26 27 27 27 27 28 29 30

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
. 00	OO100   CAP REL COSTS-BLDG & FLXT   OO200   CAP REL COSTS-MVBLE EQUIP		3, 762, 194	3, 762, 19			1.00
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT	86, 616	5, 645, 595	5, 732, 21°		1, 823, 578 5, 730, 018	2. 00 4. 00
. 00	00500 ADMINI STRATI VE & GENERAL	644, 367	13, 608, 290	14, 252, 65		14, 200, 535	
. 00	00700 OPERATION OF PLANT	289, 317	760, 610	1, 049, 92		1, 048, 124	
00	00800 LAUNDRY & LINEN SERVICE	0	0	(		0	1
00	00900 HOUSEKEEPI NG	226, 003	260, 459	486, 462	2 0	486, 462	9. 0
0. 00	01000 DI ETARY	501, 949	343, 611	845, 560	-617, 513	228, 047	10. 0
1. 00	01100 CAFETERI A	0	0	(		608, 637	•
3. 00	01300 NURSING ADMINISTRATION	503, 694	57, 768	561, 462		558, 566	•
4. 00	01400 CENTRAL SERVI CES & SUPPLY	700 ((5	0 0 0	0/2 20/	۷۱ ا	0	
5. 00 6. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	708, 665 0	254, 634 0	963, 29 <sup>9</sup>		932, 931 0	1
0. 00	INPATIENT ROUTINE SERVICE COST CENTERS	l ol	<u>U</u>		<u> </u>	0	10.00
0. 00	03000 ADULTS & PEDIATRICS	2, 114, 176	1, 215, 001	3, 329, 17	7 -531, 706	2, 797, 471	30.00
3. 00	04300 NURSERY	0	0	(		91, 446	
	ANCILLARY SERVICE COST CENTERS						
0. 00	05000 OPERATING ROOM	806, 862	1, 059, 722	1, 866, 58	4 -97, 037	1, 769, 547	50.00
1. 00	05100 RECOVERY ROOM	0	0	(	0	0	
2. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		437, 777	437, 777	
3. 00	05300 ANESTHESI OLOGY	0	0	(10.00)	٦ ١	0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C	917, 150	696, 670	1, 613, 820	-2, 169	1, 611, 651	1
6. 00 0. 00	05600 RADI OI SOTOPE 06000 LABORATORY	0	1, 829, 416	1, 829, 410	5 0	0 1, 829, 416	56. 0 60. 0
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.		1, 029, 410	1,027,410		1, 829, 410	1
6. 00	06600 PHYSI CAL THERAPY	1, 042, 619	216, 694	1, 259, 31	3 -371, 537	887, 776	1
7. 00	06700 OCCUPATI ONAL THERAPY	0	0	(		158, 306	
3. 00	06800 SPEECH PATHOLOGY	o	o	(		104, 392	•
9. 00	06900 ELECTROCARDI OLOGY	503, 227	66, 279	569, 500	-1, 339	568, 167	69.0
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 776, 675	1, 776, 67		1, 043, 042	•
2. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(		733, 633	
3. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 637, 066	3, 637, 066		3, 671, 021	
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0	76. 9
8. 00	OUTPATIENT SERVICE COST CENTERS  08800 RHC - CASS ST	0	1, 504, 160	1, 504, 160	ol o	1, 504, 160	88. 0
8. 01	08801 RHC - N. MANCHESTER		1, 390, 471	1, 390, 47	1	1, 390, 471	1
8. 02	08802 RHC - KISSINGER		607, 650	607, 650	1	607, 650	1
0.00	09000 CLI NI C	l ol	146, 850	146, 850	1	155, 726	1
0. 01	09001 SENI OR CARE	172, 448	110, 360	282, 808		282, 758	
1. 00	09100 EMERGENCY	900, 554	2, 486, 996	3, 387, 550	-3, 555	3, 383, 995	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 0
	OTHER REIMBURSABLE COST CENTERS				-1 -1		
	09500 AMBULANCE SERVICES	0	214, 628	214, 628	1	214, 628	1
01.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U U	0	(	0	0	101. 0
12 00	11300   NTEREST EXPENSE		780, 360	780, 360	-780, 360	0	113. 0
	11600 HOSPI CE	0	760, 360	760, 300			116. 00
10.00		9, 417, 647	42, 432, 159			51, 849, 806	
18 00		7, 117, 017	12, 102, 107	01,017,000	9	01,017,000	1 10.0
18. 00	INONREIMBURSABLE COST CENTERS		12, 616	29, 152	2 0	29, 152	190. 0
	NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16, 536	12,010			357, 260	192. 0
90. 00		16, 536 121, 769	235, 491	357, 260	0	337, 200	
90. 00 92. 00 92. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS			357, 260 1, 182, 772		1, 182, 772	
90. 00 92. 00 92. 01 92. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N.MANCH		235, 491 1, 182, 772 955, 370	1, 182, 772 955, 370	2 0 0	1, 182, 772 955, 370	192. 0 192. 0
90. 00 92. 00 92. 01 92. 02 92. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER		235, 491 1, 182, 772	1, 182, 772 955, 370 738, 18!	0 0 5 0	1, 182, 772 955, 370 738, 185	192. 0 192. 0 192. 0
90. 00 92. 00 92. 01 92. 02 92. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER		235, 491 1, 182, 772 955, 370 738, 185 0	1, 182, 772 955, 370 738, 18!	2 0 0 0 5 0	1, 182, 772 955, 370 738, 185 0	192. 0 192. 0 192. 0 194. 0
90. 00 92. 00 92. 01 92. 02 92. 03 94. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER 07951 FOUNDATION		235, 491 1, 182, 772 955, 370	1, 182, 772 955, 370 738, 18!	2 0 0 0 5 0	1, 182, 772 955, 370 738, 185 0 -101, 399	192. 0 192. 0 192. 0 194. 0 194. 0
90. 00 92. 00 92. 01 92. 02 92. 03 94. 00 94. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER 07951 FOUNDATION 07952 NEW DIRECTION		235, 491 1, 182, 772 955, 370 738, 185 0 -101, 399	1, 182, 77: 955, 370 738, 18! ( -101, 39	2 0 5 0 0 0 0 0 0 0	1, 182, 772 955, 370 738, 185 0 -101, 399	192. 0 192. 0 192. 0 194. 0 194. 0
92. 00 92. 01 92. 02 92. 03 94. 00 94. 01 94. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER 07951 FOUNDATION 07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES		235, 491 1, 182, 772 955, 370 738, 185 0	1, 182, 772 955, 370 738, 18!	2 0 5 0 0 0 0 0 0 0	1, 182, 772 955, 370 738, 185 0 -101, 399 0 55, 504	192. 0 192. 0 192. 0 194. 0 194. 0 194. 0
90. 00 92. 00 92. 01 92. 02 92. 03 94. 00 94. 01 94. 02 94. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER 07951 FOUNDATION 07952 NEW DIRECTION		235, 491 1, 182, 772 955, 370 738, 185 0 -101, 399	1, 182, 77: 955, 370 738, 18! ( -101, 39	2 0 5 0 0 0 0 0 0 0	1, 182, 772 955, 370 738, 185 0 -101, 399 0 55, 504	192. 0 192. 0 192. 0 194. 0 194. 0

 Health Financial
 Systems
 PARKVIEW WABA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1310 Period: From 01/01/2

Peri od: Worksheet A From 01/01/2019 Date/Time Prepared: 7/28/2020 4:40 pm

				7/28/2020 4: 4	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	I	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS			T	
1.00	00100 CAP REL COSTS-BLDG & FLXT	-169, 864			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-39, 545	1, 784, 033	•	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 362, 977	4, 367, 041		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 328, 277	10, 872, 258	•	5. 00
7.00	00700 OPERATION OF PLANT	-100, 040	948, 084		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	40, 4,0		8. 00
9.00	00900 HOUSEKEEPI NG	0	486, 462	•	9.00
10.00	01000 DI ETARY	-4, 979	223, 068		10.00
11.00	01100 CAFETERI A	-252, 641	355, 996	1	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	558, 566		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	l .	14. 00
15.00		-91, 513	841, 418	1	15. 00
16. 00		0	0		16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	070 004	0.405.077		
30.00	1 1	-372, 204	2, 425, 267	•	30.00
43. 00		0	91, 446		43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		1 7/0 547		
50.00		0	1, 769, 547		50.00
51.00	1 1	0	107 777		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	437, 777		52.00
53. 00	1 1	25 455	1 57/ 40/		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-35, 155	1, 576, 496		54.00
56.00	1	0	1 000 417		56. 00
60.00	06000 LABORATORY	0	1, 829, 416		60.00
63. 00	1 1	0	007 77/		63. 00
66.00	06600 PHYSI CAL THERAPY	0	887, 776	•	66. 00 67. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	158, 306	•	
68. 00	l l	0	104, 392	•	68. 00
69. 00	l l	0	568, 167	•	69.00
71. 00 72. 00		0	1, 043, 042	•	71. 00 72. 00
73. 00		0	733, 633		73. 00
76. 98	1 1	0	3, 671, 021 0		76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	<u> </u>			70. 70
88. 00		-22, 510	1, 481, 650		88. 00
88. 01	08801 RHC - N. MANCHESTER	-28, 126	1, 362, 345	1	88. 01
88. 02		-20, 120	607, 620	1	88. 02
90.00		-30	155, 726		90.00
90. 00	1 1	0	282, 758	•	90.00
91. 00	1	-858, 598	2, 525, 397		91.00
92. 00	1	030, 370	2, 323, 377		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
95 00	09500 AMBULANCE SERVI CES	-214, 628	0		95. 00
	010100 HOME HEALTH AGENCY	0		•	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			1.000
113. 00	0 11300   NTEREST EXPENSE	0	0		113. 00
	0 11600 HOSPI CE	o		•	116. 00
118. 00	1 1	-6, 881, 087		I .	118. 00
	NONREI MBURSABLE COST CENTERS	0,00.,00.	1177007717		1.10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-15, 202	13, 950		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	· ·	•	192. 00
	1 19201 PV WABASH HEALTH CLINC-CASS	o	1, 182, 772	•	192. 01
	2 19202 PV WABASH HEALTH CLINC-N. MANCH	0	955, 370	•	192. 02
	3 19203 PV WABASH HEALTH CLINC-KISSINGER	0	738, 185	•	192. 03
	07950 FITNESS CENTER	0	0	1	194. 00
	1 07951 FOUNDATI ON	322, 676	221, 277	l .	194. 01
	2 07952 NEW DIRECTION	022,070	221,277		194. 02
	3 07953 COMMUNITY & VOLUNTEER SERVICES	-113	55, 391		194. 03
	4 07956 OTHER NONREIMBURSABLE COST CENTERS	0	03, 371		194. 04
	5 07955 OCCUPATI ONAL HEALTH	0	١		194. 05
200.00	1 1	-6, 573, 726	48, 492, 924		200.00
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	2, 3, 3, , 20		1	,

| Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1310

					To 12/31/20	19 Date/Time Prepared: 7/28/2020 4:40 pm
		Increases			' .	1
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
	A - REHAB THERAPY RECLASS	<u> </u>				
1.00	OCCUPATI ONAL THERAPY	67.00	129, 503	28, 803		1. 00
2.00	SPEECH PATHOLOGY	68.00	85, 398	18, 994		2. 00
	0	— — <del>—                                 </del>	214, 901	47, 797		1
	B - CLINIC DIETICIAN		211,701	,		
1. 00	CLINIC	90.00	8, 876	0		1.00
1.00	0	— <del>70.</del> 00	8, 876	0		1.00
	C - CAFETERIA RECLASS		0, 070	<u> </u>		
1. 00		11.00	358, 681	249, 956		1.00
1.00	CAFETERI A					1.00
	U BRUSS SUABSER TO BATHERITE		358, 681	249, 956		
	D - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	33, 955		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
	0			33, 955		
	E - SALARY RECLASS	•		·		
1.00	ADMINISTRATIVE & GENERAL	5.00	4, 394, 731	O		1. 00
	0	— — <del>+</del>	4, 394, 731	0		
	G - DEPRECIATION	<u> </u>	1, 0, 1, 701	<u> </u>		
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 678, 768		1.00
1.00	O KEE COSTS-WVBEE EQUIT	— — <del>-</del> - <del> </del>		1, 678, 768		1.00
	U FOULD & BLDG LEAGE		<u> </u>	1,070,700		
	H - EQUIP & BLDG LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98, 775		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	131, 880		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	О		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	o	О		7.00
8.00		0.00	ol	o		8.00
9.00		0.00	0	o		9.00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	Ö		11. 00
12. 00		0.00	0	0		12. 00
		0.00	O O	0		14. 00
14. 00						14.00
	U		0	230, 655		
	I - IMPLANTABLE MEDICAL SUP.					
1.00	IMPL. DEV. CHARGED TO	72.00	0	733, 633		1.00
	PATI ENTS	oxdot				
	0		0	733, 633		
	K - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	780, 360		1.00
		$\overline{}$		780, 360		
	L - INSURANCE	· · · · · · · · · · · · · · · · · · ·	- 1	1		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27, 314		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	12, 930		2. 00
50	n	<del>                                     </del>		40, 244		2.00
	M - OB RECLASS		U	40, 244		
1 00	NURSERY	43.00	23, 936	47 510		1 00
1.00	INUE SERY	ı 43. UÜl	23, 936	67, 510		1.00
2 00			444 500	222 422		
2.00	DELIVERY ROOM & LABOR ROOM	52.00	114, 589	323, 188		2. 00
			11 <u>4, 5</u> 89 138, 525 5, 115, 714	32 <u>3, 1</u> 8 <u>8</u> 390, 698 4, 186, 066		2. 00 500. 00

| Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1310

					Т	To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm
		Decreases		_			, , , = 2, = 2 = 2
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - REHAB THERAPY RECLASS						
1. 00	PHYSI CAL THERAPY	66. 00	214, 901	47, 797			1.0
2.00		0.00		0	00		2.0
	0		214, 901	47, 797	'		
	B - CLINIC DIETICIAN						
1.00	DI ETARY	1000	<u>8, 8</u> 76	C	00		1.0
	0		8, 876	C	)		
	C - CAFETERIA RECLASS				Т		
1.00	DI ETARY	1000	358, 681	249, 956			1.0
	0		358, 681	249, 956			
	D - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15. 00	0	27, 958			1.0
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	294			2. 0
3.00	OPERATING ROOM	50.00	0	5, 665			3. 0
4.00	EMERGENCY	<u> </u>		38			4. 0
	0		0	33, 955	5		
	E - SALARY RECLASS						
1. 00	ADMINISTRATIVE & GENERAL		•	<u>4, 394, 7</u> 31			1.0
	0		0	4, 394, 731			
	G - DEPRECIATION						
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	•	<u>1, 678, 7</u> 68			1.0
	0		0	1, 678, 768	3		
	H - EQUIP & BLDG LEASE						
1.00	PHYSI CAL THERAPY	66. 00	0	98, 775			1.0
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	1, 875			2. 0
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 193			3. 0
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	11, 878			4.0
5.00	OPERATION OF PLANT	7. 00	0	1, 803			5.0
6.00	NURSING ADMINISTRATION	13. 00	0	2, 896			6.0
7.00	PHARMACY	15. 00	0	2, 410			7.0
8.00	ADULTS & PEDIATRICS	30.00	0	2, 483			8.0
9.00	OPERATING ROOM	50. 00	0	91, 372			9.0
10.00	ELECTROCARDI OLOGY	69. 00	0	1, 339			10.0
11. 00	PHYSI CAL THERAPY	66. 00	0	10, 064			11.0
12.00	EMERGENCY	91. 00	0	3, 517			12.0
14. 00	SENI OR CARE	<u>90.</u> 01		50			14.0
	0		0	230, 655	5		
	I - IMPLANTABLE MEDICAL SUP.						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	733, 633	0		1.0
	PATI ENT	+					
	0		0	733, 633	3		
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	1 <u>13.</u> 00	0	78 <u>0, 3</u> 60			1.0
	0		0	780, 360	)		
	L - I NSURANCE				1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	40, 244			1.0
2.00		0.00	•	0	12		2. 0
	0		0	40, 244	ļ		
	M - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	138, 525	390, 698			1.0
2.00		0.00		0			2. 0
	0		138, 525	390, 698			
500.00	Grand Total: Decreases		720, 983	8, 580, 797	'		500.0

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1310 Peri od: Worksheet A-7 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 7/28/2020 4:40 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 518, 481 0 1.00 0 2.00 Land Improvements 1,032,463 1, 111, 139 1, 111, 139 0 2.00 402, 184 0 3.00 44, 202, 127 402, 184 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 4, 150, 859 0 4.00 5.00 Fixed Equipment 2, 762, 870 0 0 5.00 0 6.00 Movable Equipment 23, 811, 790 359, 989 359, 989 0 6.00 0 7.00 HIT designated Assets 2, 346, 516 114, 560 114, 560 768, 710 7.00 0 8.00 Subtotal (sum of lines 1-7) 79, 825, 106 1, 987, 872 1, 987, 872 768, 710 8.00 9.00 Reconciling Items 552, 721 0 552, 721 9.00 1, 987, 872 Total (line 8 minus line 9) 79, 272, 385 1, 987, 872 215, 989 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 518, 481 1.00 2.00 Land Improvements 2, 143, 602 314, 699 2. 00 33, 184, 215 3.00 Buildings and Fixtures 44, 604, 311 3.00 4.00 Building Improvements 4, 150, 859 3, 377, 792 4.00 5.00 Fi xed Equipment 2, 762, 870 769, 970 5.00 Movable Equipment 24, 171, 779 13, 887, 258 6.00 6.00 1, 692, 366 7. 00 7.00 HIT designated Assets 1, 821, 935

81, 044, 268

81, 044, 268

53, 355, 869

53, 355, 869

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-1310	Peri od:	Worksheet A-7	
				From 01/01/2019		narodi
				To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
			SUMMARY OF CAP	PI TAL	772072020 11 1	<u>Б</u>
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)	instructions)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORL			and 2			
1.00 CAP REL COSTS-BLDG & FLXT	3, 762, 194		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)	3, 762, 194		0	0 0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (su	m			
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions)					
DART LL DESCRIPTION OF MICHIES FROM WORD	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM					
1.00 CAP REL COSTS-BLDG & FIXT	0	3, 762, 19	4			1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0 7/0 40	0			2.00
3.00  Total (sum of lines 1-2)	0	3, 762, 19	4			3. 00

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 7/28/2020 4:40	pared:
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00	CAP REL COSTS-BLDG & FIXT	55, 180, 123	l e	,,			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	23, 403, 609	l .	23, 403, 60		0	2. 00
3.00	Total (sum of lines 1-2)	78, 583, 732		78, 583, 73			3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
	·		Capi tal -Relate	cols. 5	·		
			d Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 913, 562	98, 775	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 639, 223	131, 880	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 3, 552, 785	230, 655	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions	Capital-Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	780, 360			0	2, 820, 011	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12, 700		0	1, 784, 033	2. 00
3.00	Total (sum of lines 1-2)	780, 360	40, 244		0 0	4, 604, 044	3. 00

In Lieu of Form CMS-2552-10 Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. ADJUSTMENTS TO EXPENSES Provider CCN: 15-1310 Peri od: Worksheet A-8 From 01/01/2019 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8)
Telephone services (pay 7.00 0.00 7.00 stations excluded) (chapter OPERATION OF PLANT 8.00 Tel evi si on and radio servi ce 7.00 8.00 (chapter 21) 9.00 Parking Iot (chapter 21) 9.00 0.00 Provider-based physician -1, 273, 182 10.00 A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -1, 359, 496 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -252, 641 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -82, 500 PHARMACY 15.00 17.00 pati ents 18.00 Sale of medical records and 0 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 0 00 education (tuition, fees, books, etc.) 19. 01 Nursing and allied health 19.01 0.00 education (tuition, fees, books, etc.) Nursing and allied health 19.02 0 00 19 02 education (tuition, fees, books, etc.) 19.03 Nursing and allied health 0.00 19.03 education (tuition, fees, books, etc.) 20.00 Vending machines OPERATION OF PLANT 7.00 20.00 В 0 21 00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 0 \*\*\* Cost Center Deleted \*\*\* Adjustment for respiratory 23.00 A-8-3 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 Utilization review -114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 26.00 COSTS-BLDG & FLXT Depreciation - CAP REL 27.00 OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP

\*\* Cost Center Deleted \*\*\*

19.00

0.00

28.00

0 29.00

Non-physician Anesthetist

29.00 Physicians' assistant

28.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-1310 Peri od: Worksheet A-8 From 01/01/2019
To 12/31/2019 Date/Time Prepared:

					5 12/31/2019	7/28/2020 4:40	
				Expense Classification on	Worksheet A	172072020 4.4	Э рііі
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		_				
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
22.00	limitation (chapter 14)		0		0.00	0	22.00
32. 00	CAH HIT Adjustment for		Ü		0. 00	U	32. 00
33. 00	Depreciation and Interest DEPRECIATION HIT ASSETS	A	1 111	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33.00	2016	A	-4, 111	ADMINISTRATIVE & GENERAL	5.00	U	33.00
33. 01	DEPRECIATION HIT ASSETS	A	_138 708	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 01	PRIOR		130, 700	ADMINISTRATIVE & GENERAL	5.00		33. 01
33. 02	DEPRECIATION-OLD HOSP	A	-169 864	CAP REL COSTS-BLDG & FLXT	1. 00	9	33. 02
34. 00	RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5. 00	Ó	34.00
38. 00	SELF INSURANCE ADJUSTMENT	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o o	38. 00
39. 00	LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	o o	39. 00
40. 00	MARKETING	A		ADMI NI STRATI VE & GENERAL	5. 00	ő	40. 00
40. 01	TELEVI SI ON	A		OPERATION OF PLANT	7. 00	ő	40. 01
40. 02	MARKETING	A	·	COMMUNITY & VOLUNTEER	194. 03	o	40. 02
				SERVI CES			
40. 03	340B RETAIL	A	-9, 013	PHARMACY	15. 00	0	40. 03
42.00	LIQUOR ADJUSTMENT	A	-225	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
42.01	OTHER OPERATING REVENUE	A	-2, 419	ADMINISTRATIVE & GENERAL	5. 00	0	42. 01
42.02	TV	A	-39, 545	CAP REL COSTS-MVBLE EQUIP	2. 00	9	42. 02
44.00	EMS ADJUSTMENT	A	-204, 044	AMBULANCE SERVICES	95. 00	0	44.00
45.00	TELEMETRY MONITORING	A	31, 796	ADULTS & PEDIATRICS	30.00	0	45.00
45. 01	RHC N MANCHESTER ADJUSTMENTS	A	-28, 126	RHC - N. MANCHESTER	88. 01	0	45. 01
	(M-1)						
45. 02	PURCHASING DI SCOUNTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
46. 01	HHH ADJUSTMENT	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	46. 01
48. 00	OTHER OPERATING REV	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	48. 00
49. 00	OTHER OPERATING REV	A	·	DI ETARY	10. 00	0	49. 00
49. 01	OTHER OPERATING REV	A	-15, 202	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	49. 01
				CANTEEN			
49. 02	HEARTSMART SCAN READS	A		RADI OLOGY-DI AGNOSTI C	54.00	0	49. 02
49. 03	HAF FEE EXPENSE ADJUSTMENT	A		ADMI NI STRATI VE & GENERAL	5. 00	0	49. 03
49. 04	HOSPITALIST AVAILABILITY	A	0	ADULTS & PEDIATRICS	30. 00	0	49. 04
40.05	COVERAGE		00.050	ODEDATION OF DIANT	7.00		40.05
49. 05	PHYSICIAN CLINIC RENT OFFSET	В		OPERATION OF PLANT	7. 00	0	49. 05
49. 06	REMOVE FOUNDATION REVENUE	A		FOUNDATI ON	194. 01	0	49. 06
49. 07	RHC CASS ADJUSTMENTS (M-1)	A	,	RHC - CASS ST	88. 00	0	49. 07
49. 08	RHC KISSINGER ADJUSTMENTS	A	-30	RHC - KI SSI NGER	88. 02	0	49. 08
50. 00	(M-1)		4 572 704				EO 00
ou. uu	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-6, 573, 726				50. 00
	column 6, line 200.)						
(4) D				0110 D L 45 4			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(1)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

\* 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.

9, 434, 574

10, 794, 070

5.00

 zoon pootou to normonout m	cor anni s r aria, or 2, tric anoar	it aironabro on		or time parti	
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	0. 00 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

5.00

line 12.

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

Health Financial Systems			PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-			MS-2552-10	
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS			RELATED ORGANI ZAT	TIONS AND HOME	Provi der CCN: 1	15-1310	Period: From O	1/01/2019	Worksheet	A-8-1
OTTTOL	00010						To 12	2/31/2019	Date/Ti me 7/28/2020	
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.								
	6. 00	7. 00								
	A. COSTS INCURI HOME OFFICE CO:		MENTS REQUIRED AS	A RESULT OF TRA	ANSACTIONS WITH	RELATED 0	RGANI ZA	TIONS OR (	CLAI MED	
1.00	2, 505, 186	C								1.00
2. 00	-3, 864, 682	C								2. 00
3.00	0	C								3. 00
4.00	0	C								4. 00
5.00	-1, 359, 496									5. 00
			oscripts as approp se cost and negati							

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part. Related Organization(s) and/or Home Office Type of Business 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	HEALTH SYSTEM	6. 00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						0 12/31/2019	7/28/2020 4:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	91. 00	EMERGENCY	1, 971, 000	858, 598	1, 112, 402	0	0	1. 00
2.00	90. 01	SENI OR CARE	32, 677	· C		0	0	2. 00
3.00	95. 00	AMBULANCE SERVICES	10, 584	10, 584	. 0	0	0	3. 00
4.00	30.00	DR. F	404, 000	404, 000	0	0	0	4. 00
5.00	0.00		0	ol c	0	0	0	5. 00
6.00	0.00		0	ol c	0	0	0	6. 00
7.00	0.00		0	ol c	0	0	0	7. 00
8.00	0.00		0	l c	0	0	0	8. 00
9.00	0.00		0	l c	0	0	0	9. 00
10.00	0.00		0	l c	0	0	0	10.00
200.00			2, 418, 261	1, 273, 182	1, 145, 079		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		EMERGENCY	0	1	_			
2.00		SENI OR CARE	0	1		0	1	
3.00		AMBULANCE SERVICES	0	O C	0	0	0	
4.00		DR. F	0	) C	0	0	0	1
5.00	0. 00		0	l C	0	0	0	0.00
6.00	0. 00		0	) c	0	0	0	6. 00
7.00	0. 00		0	) c	0	0	0	,
8.00	0. 00		0	) c	0	0	0	8. 00
9.00	0. 00		0	) c	0	0	0	7.00
10.00	0. 00		0	) C	0	0	0	
200.00		45.	0	C	0	0	0	200.00
	Wkst. A Line #	l	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	13.00			858, 598		1.00
2. 00		ISENI OR CARE		1	_	030, 370		2.00
3. 00		AMBULANCE SERVICES			_	10, 584		3. 00
4. 00		DR. F				404, 000		4.00
5. 00	0.00				_	404,000	1	5. 00
6. 00	0.00				9	0		6.00
7. 00	0.00					0		7. 00
8. 00	0.00				0	0		8.00
9. 00	0.00			1	0	0		9.00
10. 00	0.00			1	0	0		10.00
200.00	3.00			1		1, 273, 182		200.00
200.00	I	I	1	1		1,270,102	I	

COST A	ALLOCAT	TION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2019	Worksheet B Part I	
						To 12/31/2019	Date/Time Pre	
				CAPI TAL REI	LATED COSTS		7/28/2020 4: 4	O pm
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
			Allocation			BENEFITS DEPARTMENT		
			(from Wkst A			DEI / II / III / III		
			col . 7)					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	2, 820, 011	2, 820, 011				1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP	1, 784, 033	2,020,011	1, 784, 03	3		2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	4, 367, 041	0	1	0 4, 367, 041		4. 00
5.00		ADMINISTRATIVE & GENERAL	10, 872, 258	789, 416			13, 748, 352	1
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	948, 084	327, 273	1	4 91, 132 0 0	1, 573, 533 0	1
9. 00		HOUSEKEEPING	486, 462	61, 669		-	658, 334	9.00
10.00	1	DI ETARY	223, 068	70, 727			380, 871	10.00
11. 00		CAFETERI A	355, 996	126, 258	79, 87	5 112, 981	675, 110	
13.00		NURSI NG ADMI NI STRATI ON	558, 566	5, 435			726, 098	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0 841, 418	0 104, 334		0 5 223, 222	0 1, 234, 979	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	041, 410	104, 334	1	0 223, 222	1, 254, 777	
		IENT ROUTINE SERVICE COST CENTERS	-1			-		1
30.00		ADULTS & PEDIATRICS	2, 425, 267	256, 583			3, 466, 483	1
43. 00		NURSERY	91, 446	3, 808	2, 40	9 7, 540	105, 203	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 769, 547	278, 840	176, 40	3 254, 153	2, 478, 943	50.00
51. 00		RECOVERY ROOM	0	0	170, 10	0 201, 100	2, 170, 710	1
52.00	05200	DELIVERY ROOM & LABOR ROOM	437, 777	31, 426	19, 88	1 36, 094	525, 178	52. 00
53.00		ANESTHESI OLOGY	0	0		0 0	0	
54. 00 56. 00		RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	1, 576, 496	234, 955	148, 64	0 288, 893 0 0	2, 248, 984 0	1
60.00	1	LABORATORY	1, 829, 416	128, 809	81, 48	-	2, 039, 714	1
63. 00		BLOOD STORING, PROCESSING & TRANS.	0	0	0.7.10	o o	0	1
66. 00	06600	PHYSI CAL THERAPY	887, 776	13, 680	8, 65	4 260, 723	1, 170, 833	66. 00
67. 00		OCCUPATIONAL THERAPY	158, 306	0		0 40, 792	199, 098	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	104, 392 568, 167	0 105, 628		0 26, 900 4 158, 511	131, 292 899, 130	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	1, 043, 042	103, 028	1	0 0	1, 043, 042	1
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	733, 633	0	1	0 0	733, 633	
73. 00	1	DRUGS CHARGED TO PATIENTS	3, 671, 021	0	1	0 0	3, 671, 021	73. 00
76. 98		HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
88. 00		TIENT SERVICE COST CENTERS RHC - CASS ST	1, 481, 650	0		0 0	1, 481, 650	88. 00
88. 01	1	RHC - N. MANCHESTER	1, 362, 345	0	1	0 0	1, 362, 345	1
88. 02		RHC - KISSINGER	607, 620	0		0	607, 620	
90. 00		CLINIC	155, 726	4, 215			165, 403	1
90. 01		SENI OR CARE	282, 758	37, 304			397, 981	
	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	2, 525, 397	215, 397	136, 26	7 283, 666	3, 160, 727 0	
72.00		REIMBURSABLE COST CENTERS						72.00
95. 00		AMBULANCE SERVICES	0	0		0 0	0	
101.00		HOME HEALTH AGENCY	0	0		0 0	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			I			113. 00
	1	HOSPI CE	0	0		0	0	116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44, 968, 719	2, 795, 757	1, 768, 69		44, 885, 557	
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	13, 950	14, 715	1			190.00
	1	PHYSICIANS' PRIVATE OFFICES PV WABASH HEALTH CLINC-CASS	357, 260 1, 182, 772	0		0 38, 356 0 0	395, 616 1, 182, 772	
		PV WABASH HEALTH CLINC-N. MANCH	955, 370	0		0 0	955, 370	
192.03	19203	PV WABASH HEALTH CLINC-KISSINGER	738, 185	0		0 0	738, 185	
		FI TNESS CENTER	0	0	1	0 0		194. 00
		FOUNDATION	221, 277	9, 539	1		236, 850	1
		NEW DIRECTION   COMMUNITY & VOLUNTEER SERVICES	55, 391	0	1	0 0		194. 02 194. 03
		OTHER NONREIMBURSABLE COST CENTERS	0	0		o o		194. 04
194.05	07955	OCCUPATIONAL HEALTH	0	0		0 0	0	194. 05
200.00	1	Cross Foot Adjustments		^				200.00
201. 00 202. 00	1	Negative Cost Centers TOTAL (sum lines 118 through 201)	48, 492, 924	0 2, 820, 011	1, 784, 03	0 3 4, 367, 041	0 48, 492, 924	201.00
202.00	1	TOTAL (Sum TITIES TTO CHI OUGH 201)	10, 472, 724	2, 020, 011	1, 704, 03	5, 7, 507, 041	70, 472, 724	1202.00

Provider CCN: 15-1310

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
7/28/2020 4:40 pm	

				'	0 12/31/2019	7/28/2020 4: 4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS			T	T T		
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	40 740 050					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	13, 748, 352	0.40/.477				5. 00
7.00	00700 OPERATION OF PLANT	622, 644	2, 196, 177				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2/0 501	70 512	C	000 240		8. 00
9.00	00900 HOUSEKEEPI NG	260, 501	79, 513		998, 348	// = 705	9.00
10.00	01000 DI ETARY	150, 710	91, 192		43, 012	665, 785	1
11.00	01100 CAFETERI A	267, 140	162, 791		76, 782	0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	287, 316	7, 007	C	3, 305	0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	124 522		(2.440	0	
15. 00	01500 PHARMACY	488, 679	134, 523			0	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	C	l O	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 271 (00	220, 027	1	157 000	//	20.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 371, 680	330, 826			665, 785	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	41, 629	4, 910	C	2, 316	0	43. 00
EO 00	05000 OPERATING ROOM	980, 913	359, 523		169, 571	0	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	980, 913	339, 323			0	
51.00	05200 DELIVERY ROOM & LABOR ROOM	1	40 E10			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	207, 812	40, 519		19, 111	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	889, 918	202 020		142 005	0	
56. 00	05600 RADI OLOGY - DI AGNOSTI C	009, 910	302, 939		142, 885	0	
60.00	06000 LABORATORY	907 111	144 000		70 224	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	807, 111	166, 080		78, 334	0	1
66. 00	06600 PHYSI CAL THERAPY	463, 296	17, 638		8, 319	0	
67. 00	06700 OCCUPATI ONAL THERAPY	1	17,030		0, 319	0	
		78, 783	0		0	_	
68. 00	06800 SPEECH PATHOLOGY	51, 952	127 101		(4.224	0	
69. 00	06900 ELECTROCARDI OLOGY	355, 784	136, 191		64, 236	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	412, 730	0		U	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	290, 297	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 452, 610	0		0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
00 00	OUTPATIENT SERVICE COST CENTERS  08800 RHC - CASS ST	E04 204	0		O		00 00
88. 00		586, 286	0		0	0	1
88. 01	08801 RHC - N. MANCHESTER	539, 077	0		U	_	
88. 02	08802 RHC - KISSINGER	240, 434	U 5 424		2.5(2)	0	
90.00	09000 CLINIC	65, 450	5, 434		2, 563	0	
90. 01	09001 SENI OR CARE	157, 480	48, 098		22, 686	0	
91.00	09100 EMERGENCY	1, 250, 693	277, 722	C	130, 991	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00	OTHER REI MBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES		0		ا	0	05 00
	109500  AMBULANCE SERVICES   10100  HOME HEALTH AGENCY	0	0			0	95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	C	ı U	0	1101.00
112 00	11300   NTEREST EXPENSE			ı			113. 00
	11600 HOSPI CE	0	0	0	o	0	116.00
118.00		12, 320, 925	2, 164, 906				
118.00	NONREI MBURSABLE COST CENTERS	12, 320, 925	2, 104, 900		983, 598	000, 780	1118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 087	18, 972		8, 949	0	190. 00
		1	18, 9/2				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	156, 544	0				
	19201 PV WABASH HEALTH CLINC-CASS	468, 021	0	C	U		192. 01
	19202 PV WABASH HEALTH CLINC-N. MANCH	378, 038	0		0		192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER	292, 098	0		0		192. 03
	07950 FITNESS CENTER	0	0		0		194. 00
	07951 FOUNDATI ON	93, 721	12, 299	0	5, 801		194. 01
	2 07952 NEW DIRECTION	0	0	0	0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	21, 918	0	l c	0		194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	07955 OCCUPATI ONAL HEALTH	0	0	0	0	0	194. 05
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 748, 352	2, 196, 177	[ c	998, 348	665, 785	202. 00

Provider CCN: 15-1310

				То	12/31/2019	Date/Time Pre 7/28/2020 4:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	13. 00	SUPPLY 14.00	15. 00	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	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 181, 823					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	52, 311	1, 076, 037				13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	02,011	0	0			14. 00
15. 00	01500 PHARMACY	84, 355	o	Ö	2, 005, 985		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDI ATRI CS	334, 662		0	40, 329	0	30.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	23, 884	0	0	0	43. 00
50. 00	05000 OPERATING ROOM	115, 445	208, 949	0	7, 158	0	50.00
51.00	05100 RECOVERY ROOM	115, 445	200, 949	0	7, 130	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		114, 323	Ö	o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	2, 789	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	172, 849	o	0	18, 888	0	54.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
60.00	06000 LABORATORY	0	0	0	2, 084	0	60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600 PHYSI CAL THERAPY	139, 743		0	124, 416	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	13, 370 10, 823		0	10, 351 2, 117	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	83, 506		0	2, 117	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	00,000	ő	Ö	Ö	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	Ö	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	0	1, 744, 148	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS		1		اء		
88. 00	08800 RHC - CASS ST	0	0	0	0	0	88. 00
88. 01 88. 02	08801 RHC - N. MANCHESTER 08802 RHC - KI SSI NGER		0	0	0	0	88. 01 88. 02
90. 00	09000 CLI NI C	1, 486	0	0	0	0	90.00
90. 01	09001 SENI OR CARE	28, 755		Ö	o	0	90. 01
91.00	09100 EMERGENCY	144, 518		0	23, 122	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	T _	T	_T	_T		
95. 00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	o	0	0	0	116. 00
118.00		1, 181, 823	1, 076, 037	0	1, 975, 402		118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 PV WABASH HEALTH CLINC-CASS   19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0		192. 01 192. 02
	19202 PV WABASH HEALTH CLINC-N. MANCH 3 19203 PV WABASH HEALTH CLINC-KISSINGER		0	0	0		192. 02
	07950 FITNESS CENTER		0	0	0		194. 00
	07951 FOUNDATION	0	l ol	0	30, 583		194. 00
	07952 NEW DIRECTION	0	o	Ö	0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	o	0	О		194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	07955 OCCUPATI ONAL HEALTH	0	이	0	0	0	194. 05
200.00						^	200. 00 201. 00
201. 00 202. 00		1, 181, 823	1, 076, 037	0	2, 005, 985		201.00
202.00	1.01/1E (30m 111103 110 through 201)	1, 101, 023	1,070,037	Ч	2, 303, 703	0	1-02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2019 Part I Provider CCN: 15-1310

							ime Prepared:
		Cost Center Description	Subtotal	Intern &	Total	1/28/20	020 4:40 pm
				Residents Cost & Post Stepdown			
				Adjustments			
	loeuen	AL OFFICE COOK OFFICE	24. 00	25. 00	26. 00		
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT		1			1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	1	ADMINISTRATIVE & GENERAL					5. 00
7.00	1	OPERATION OF PLANT					7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING					8. 00 9. 00
10. 00	1	DI ETARY					10.00
11. 00	1	CAFETERI A					11. 00
13.00	01300	NURSING ADMINISTRATION					13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY					14. 00
	1	PHARMACY MEDICAL DECORDS & LIBRARY					15.00
16.00		MEDICAL RECORDS & LIBRARY I ENT ROUTINE SERVICE COST CENTERS					16. 00
30. 00		ADULTS & PEDIATRICS	6, 833, 144	O	6, 833, 144	1	30.00
43. 00		NURSERY	177, 942		177, 942		43. 00
		LARY SERVICE COST CENTERS					
50.00	1	OPERATI NG ROOM	4, 320, 502	1	4, 320, 502		50.00
51. 00 52. 00	1	RECOVERY ROOM	004 043	0 0	004 043	1	51.00
52.00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	906, 943 2, 789		906, 943 2, 789		52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	3, 776, 463		3, 776, 463		54. 00
56.00	1	RADI OI SOTOPE	C	o	(		56.00
60.00		LABORATORY	3, 093, 323	o o	3, 093, 323	3	60.00
63. 00		BLOOD STORING, PROCESSING & TRANS.	1 004 045	0	1 004 04	2	63.00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 924, 245 301, 602		1, 924, 245 301, 602		66. 00 67. 00
68. 00		SPEECH PATHOLOGY	196, 184	1	196, 184		68. 00
69. 00	1	ELECTROCARDI OLOGY	1, 538, 847		1, 538, 847		69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 455, 772	2 o	1, 455, 772	2	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	1, 023, 930		1, 023, 930		72. 00
73. 00 76. 98		DRUGS CHARGED TO PATIENTS HYPERBARIC OXYGEN THERAPY	6, 867, 779 0		6, 867, 779		73. 00 76. 98
70. 70		TIENT SERVICE COST CENTERS		η Ο		1	70. 70
88. 00		RHC - CASS ST	2, 067, 936	0	2, 067, 936		88. 00
88. 01		RHC - N. MANCHESTER	1, 901, 422		1, 901, 422		88. 01
		RHC - KISSINGER	848, 054		848, 054		88. 02
90. 00 90. 01	1	CLINIC SENIOR CARE	240, 336 916, 540		240, 336 916, 540		90. 00
91. 00	1	EMERGENCY	4, 987, 773		4, 987, 773		91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	1,707,770	o	1,707,77		92. 00
		REIMBURSABLE COST CENTERS					
		AMBULANCE SERVICES	C				95. 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	С	0	(		101. 00
113.00		INTEREST EXPENSE					113. 00
	1	HOSPI CE	C	o	(		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43, 381, 526	0	43, 381, 526	)	118. 00
400.00		IMBURSABLE COST CENTERS	00.404	1 0	00.404		100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	88, 191 552, 160	1	88, 19 <sup>2</sup> 552, 160		190. 00 192. 00
		PV WABASH HEALTH CLINC-CASS	1, 650, 793		1, 650, 793		192. 01
		PV WABASH HEALTH CLINC-N. MANCH	1, 333, 408		1, 333, 408		192. 02
		PV WABASH HEALTH CLINC-KISSINGER	1, 030, 283	8  O	1, 030, 283	3	192. 03
		FITNESS CENTER	270.254	0	270.25	2	194. 00
	1	FOUNDATION NEW DIRECTION	379, 254		379, 25 <sup>4</sup>	,	194. 01 194. 02
		COMMUNITY & VOLUNTEER SERVICES	77, 309		77, 309		194. 02
		OTHER NONREIMBURSABLE COST CENTERS	.,, 50,	ol ől	, , , 50	)	194. 04
194. 05	07955	OCCUPATIONAL HEALTH	C	ol ol	(	)	194. 05
200.00		Cross Foot Adjustments	C	이	(	)	200. 00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	48, 492, 924	0	48, 492, 92 <sup>4</sup>	) 1	201. 00 202. 00
ZUZ. UU	<b>'</b> I	TOTAL (Suill TITIES TTO TITLOUGH ZUT)	40, 472, 724	n 이	40, 472, 924	ř	1202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1310

				To	12/31/2019	Date/Time Pre 7/28/2020 4:4	
			CAPI TAL REI	LATED COSTS		17/20/2020 4.4	Dill Dill
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Assigned New Capital				DEPARTMENT	
		Rel ated Costs				DELAKTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	848, 390	789, 416	499, 414	2, 137, 220	0	
7. 00	00700 OPERATION OF PLANT	0	327, 273		534, 317	0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	61, 669	·	100, 683	0	
10.00	01000 DI ETARY	0	70, 727		115, 471	0	
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	126, 258 5, 435		206, 133 8, 873	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	ე, 430 	3, 436	0, 0/3	0	
15. 00	01500 PHARMACY	0	104, 334	_	170, 339	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	256, 583		418, 906	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	3, 808	2, 409	6, 217	0	43. 00
50. 00		0	278, 840	176, 403	455, 243	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	31, 426	19, 881	51, 307	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	234, 955	148, 640	383, 595	0	
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	0	128, 809	81, 489	210, 298	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	120, 009	01, 407	210, 270	0	
66. 00	06600 PHYSI CAL THERAPY	0	13, 680	8, 654	22, 334	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	105, 628	66, 824	172, 452	0	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	1
73. 00		0	Ö	Ö	Ö	0	1
76. 98	I I	0	0	0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RHC - CASS ST	0	0	0	0	0	1
88. 01 88. 02	08801 RHC - N. MANCHESTER 08802 RHC - KISSINGER	0	0	0	0	0	
90.00	09000 CLINIC	0	4, 215	2, 666	6, 881	0	
90. 01	09001 SENI OR CARE	0	37, 304		60, 904	0	
91.00	09100 EMERGENCY	0	215, 397		351, 664	0	91.00
92. 00	`				0		92. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1 0	0	0	٥	0	05.00
	010100 HOME HEALTH AGENCY	0	) 		0		95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS			1 9	<u> </u>		101.00
113.00	11300   NTEREST EXPENSE						113. 00
	D 11600 HOSPI CE	0	0	0	0		116. 00
118. 00		848, 390	2, 795, 757	1, 768, 690	5, 412, 837	0	118. 00
100 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	14 715	9, 309	24 024	0	190. 00
	019200 PHYSI CLANS' PRI VATE OFFI CES	0	14, 715 0	9, 309	24, 024 0		190.00
	1 19201 PV WABASH HEALTH CLINC-CASS	0	Ö	Ö	Ö		192. 01
	2 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0		192. 02
	3 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192. 03
	007950 FI TNESS CENTER	0	0	0	0		194. 00
	1 07951 FOUNDATION 2 07952 NEW DIRECTION	0	9, 539	6, 034	15, 573		194. 01 194. 02
	3 07952 NEW DIRECTION 3 07953 COMMUNITY & VOLUNTEER SERVICES		"		O O		194. 02
	4 07956 OTHER NONREIMBURSABLE COST CENTERS	0	0		ol		194. 03
	07955 OCCUPATI ONAL HEALTH	0	0	o	o		194. 05
200.00	1 1				0		200. 00
201.00	1 1 0	0.40, 000	0 000 011	0	0		201. 00
202. 00	D   TOTAL (sum lines 118 through 201)	848, 390	2, 820, 011	1, 784, 033	5, 452, 434	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

				11	0 12/31/2019	7/28/2020 4:4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, , , , , , , , , , , , , , , , , , ,
	·	& GENERAL	PLANT	LINEN SERVICE			
	OFFICE AND ASSESSED ASSESSEDA ASSESSED ASSESSED ASSESSED ASSESSED ASSESSED ASSESSED ASSESSEDA	5. 00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BLDG & FTXT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 137, 220					5. 00
7.00	00700 OPERATION OF PLANT	96, 791	631, 108				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	O	0				8. 00
9.00	00900 HOUSEKEEPI NG	40, 495	22, 849		164, 027		9. 00
10.00	01000 DI ETARY	23, 428	26, 205		7, 067	172, 171	1
11.00	01100 CAFETERI A	41, 527	46, 781		12, 615		
13.00	01300 NURSI NG ADMI NI STRATI ON	44, 664	2, 014		543		1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	75, 966	0 38, 657		0 10, 425	0	
16. 00	01600 MEDICAL RECORDS & LIBRARY	75, 700	38, 637				1
10.00	I NPATIENT ROUTINE SERVICE COST CENTERS	٥			<u> </u>		10.00
30.00	03000 ADULTS & PEDIATRICS	213, 230	95, 068	0	25, 637	172, 171	30.00
43.00	04300 NURSERY	6, 471	1, 411	0	380	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	152, 485	103, 315			0	
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	32 205	11 (44			0	
52. 00 53. 00	05300 ANESTHESI OLOGY	32, 305	11, 644	0	3, 140	[ 0   0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	138, 340	87, 055		23, 476		
56. 00	05600 RADI OI SOTOPE	0	07,000	ő	0	Ö	1
60.00	06000 LABORATORY	125, 467	47, 726	o	12, 870	O	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	72, 020	5, 068	0	1, 367	0	
67. 00	06700 OCCUPATI ONAL THERAPY	12, 247	0		0	0	
68. 00	06800 SPEECH PATHOLOGY	8, 076	20.127	0	10 554	0	
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	55, 307 64, 160	39, 137	_	10, 554	0	1 07.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	45, 127	0		0		
73. 00	07300 DRUGS CHARGED TO PATIENTS	225, 824	0		0		1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0		1
	OUTPATIENT SERVICE COST CENTERS	'		•			
88. 00	08800 RHC - CASS ST	91, 139	0	0	0	0	1
88. 01	08801 RHC - N. MANCHESTER	83, 801	0			0	
88. 02	08802 RHC - KI SSI NGER	37, 376	0	0	0	0	
90. 00 90. 01	09000   CLI NI C   09001   SENI OR CARE	10, 174	1, 562	1	421 3, 727	0	
91.00	09100 EMERGENCY	24, 481 194, 423	13, 822 79, 808	1	· ·		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	174, 425	77,000		21, 522		92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	0	0	0	O	95. 00
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
110 0	SPECIAL PURPOSE COST CENTERS						112 00
	D 11300   NTEREST EXPENSE D 11600   HOSPI CE		0	0	0	_	113. 00 116. 00
118.00		1, 915, 324	622, 122			172, 171	
110.00	NONREI MBURSABLE COST CENTERS	1, 715, 524	022, 122		101, 004	172, 171	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 656	5, 452	0	1, 470	O	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	24, 335	0	1		O	192. 00
192.0	1 19201 PV WABASH HEALTH CLINC-CASS	72, 755	0	0	0	0	192. 01
	2 19202 PV WABASH HEALTH CLINC-N. MANCH	58, 767	0	0	0		192. 02
	3 19203 PV WABASH HEALTH CLINC-KISSINGER	45, 407	0	0	0		192. 03
	007950 FITNESS CENTER	0	0	0			194. 00
	1 07951 FOUNDATION 2 07952 NEW DIRECTION	14, 569	3, 534	0	953 0		194. 01 194. 02
	2 07952 NEW DIRECTION 3 07953 COMMUNITY & VOLUNTEER SERVICES	3, 407	0		0		194. 02
	4 07956 OTHER NONREIMBURSABLE COST CENTERS	3, 407	0	0	0		194. 03
	07955 OCCUPATI ONAL HEALTH		0	o o	0		194. 05
200.00	1						200. 00
201.00		0	0	0			201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 137, 220	631, 108	0	164, 027	172, 171	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1310

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared:

				То	12/31/2019	Date/Time Pre 7/28/2020 4:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	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	00900 HOUSEKEEPI NG						9.00
10.00	01000   DI ETARY   01100   CAFETERI A	207.054					10.00
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	307, 056 13, 591	69, 685				11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	13, 391	09, 000	0			14. 00
15. 00	01500 PHARMACY	21, 917		0	317, 304		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	21, 717	Ö	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		-1				
30.00	03000 ADULTS & PEDIATRICS	86, 951	30, 264	0	6, 379	0	30. 00
43.00	04300 NURSERY	0	1, 547	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	29, 994		0	1, 132	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 404	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	44. 909	0	0	441	0	53. 00 54. 00
54. 00 56. 00	05400  RADI OLOGY-DI AGNOSTI C   05600  RADI OI SOTOPE	44, 909	0	0	2, 988	0	56.00
60. 00	06000 LABORATORY		0	0	330	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			0	0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	36, 307	l o	0	19, 680	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	3, 474	o	Ö	1, 637	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 812	o	0	335	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	21, 696	o	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	275, 887	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
99 00	OUTPATIENT SERVICE COST CENTERS  08800 RHC - CASS ST	0	O	0	ام	0	88. 00
88. 00 88. 01	O8801 RHC - N. MANCHESTER		0	0	0	0	88. 01
88. 02	08802 RHC - KISSINGER			0	0	0	88. 02
90. 00	09000 CLINIC	386	Ö	0	o	0	90.00
90. 01	09001 SENI OR CARE	7, 471	16, 938	Ö	o	0	90. 01
91.00	09100 EMERGENCY	37, 548		0	3, 657	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0		0	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	0	0	116. 00
118.00	1 1	307, 056		Ö	312, 466		118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			, , , , , ,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19201 PV WABASH HEALTH CLINC-CASS	0	0	0	0		192. 01
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0		192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192. 03
	07950 FITNESS CENTER	0	0	0	4 020		194. 00
	07951  FOUNDATION  07952  NEW DIRECTION			0	4, 838		194. 01 194. 02
	07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES			0	0		194. 02
	07956 OTHER NONREIMBURSABLE COST CENTERS	0		0	0		194. 03
	07955 OCCUPATIONAL HEALTH	0	ا	Ö	ő		194. 05
200.00	1 1				٦	· ·	200. 00
201.00	Negative Cost Centers	0	o	0	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	307, 056	69, 685	0	317, 304	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

				rom 01/01/2019   Part II o 12/31/2019   Date/Time Pr	
Cost Center Description	Subtotal	Intern &	Total	7/28/2020 4:	40 pili
		Residents Cost & Post			
		Stepdown			
	24. 00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS				I	1 00
1.00   00100   CAP REL COSTS-BLDG & FIXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT					5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A					10.00
13. 00 O1300 NURSING ADMINISTRATION					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00   01500  PHARMACY 16. 00   01600  MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS 43. 00   04300   NURSERY	1, 048, 606	0	1, 048, 606 16, 026		30. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	16, 026	UU	10, 020		43.00
50. 00 05000 OPERATING ROOM	783, 561	0	783, 561		50. 00
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0 105, 800	0	0 105, 800		51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	441	0	441		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	680, 363	0	680, 363		54.00
56. 00   05600   RADI 0I SOTOPE 60. 00   06000   LABORATORY	0 396, 691	0	396, 691		56. 00 60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	156, 776	0	156, 776		66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY	17, 358 11, 223	0	17, 358 11, 223		68. 00
69. 00 06900 ELECTROCARDI OLOGY	299, 146	0	299, 146		69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	64, 160 45, 127	0	64, 160 45, 127		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	501, 711	Ö	501, 711		73. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0	0		76. 98
88.00 OBSOO RHC - CASS ST	91, 139	0	91, 139		88. 00
88. 01   08801   RHC - N. MANCHESTER	83, 801	0	83, 801		88. 01
88. 02   08802   RHC - KI SSI NGER 90. 00   09000   CLI NI C	37, 376 19, 424	0	37, 376 19, 424		88. 02 90. 00
90. 01   09001   SENI OR CARE	127, 343	0	127, 343		90.00
91. 00 09100 EMERGENCY	688, 622	0	688, 622		91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0		95. 00
101. 00 10100 HOME HEALTH AGENCY  SPECIAL PURPOSE COST CENTERS	0	0	0		101. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 H0SPI CE	o	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 174, 694	0	5, 174, 694		118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 602	0	33, 602		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	24, 335	0	24, 335		192.00
192. 01 19201  PV WABASH HEALTH CLINC-CASS 192. 02 19202  PV WABASH HEALTH CLINC-N. MANCH	72, 755 58, 767	0	72, 755 58, 767		192. 01 192. 02
192.03 19203 PV WABASH HEALTH CLINC-KISSINGER	45, 407	0	45, 407		192. 03
194. 00 07950  FI TNESS CENTER 194. 01 07951  FOUNDATI ON	0 39, 467	0	0 39, 467		194. 00 194. 01
194. 02 07952 NEW DIRECTION	0	0	39, 407		194. 02
194. 03 07953 COMMUNITY & VOLUNTEER SERVICES	3, 407	0	3, 407		194. 03
194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 194. 05 07955 OCCUPATIONAL HEALTH		0	0		194. 04 194. 05
200.00 Cross Foot Adjustments	Ö	o	0		200. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0 5, 452, 434	0	0 5, 452, 434		201. 00 202. 00
202.00   TOTAL (Suil TITIES TTO LITTUUGIT 201)	J, 402, 434	Ч	5, 452, 434	I	1202.00

	Financial Systems P LLOCATION - STATISTICAL BASIS	ARKVIEW WABASH	HOSPITAL, INC.	CN: 1E 1210	In Li∈ Period:	worksheet B-1	
CUST	ILLUCATION - STATISTICAL BASIS		Provider C	F	From 01/01/2019		
					Го 12/31/2019	Date/Time Pre 7/28/2020 4:4	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
	T	1. 00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS    OO100   CAP REL COSTS-BLDG & FIXT	76, 275	I	1		I	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	70,273	76, 275	i			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	O	13, 864, 067			4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	21, 352					1
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	8, 852	8, 852			1, 573, 533 0	1
9. 00	00900 HOUSEKEEPI NG	1, 668	1	1	3 0	658, 334	
10.00	01000 DI ETARY	1, 913				380, 871	1
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	3, 415 147	3, 415 147			675, 110 726, 098	
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	1		1	1
15. 00	01500 PHARMACY	2, 822	2, 822	708, 665	5 0	1, 234, 979	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	) (	0	0	16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	6, 940	6, 940	1, 975, 65	1 0	3, 466, 483	30.00
	04300 NURSERY	103					1
	ANCILLARY SERVICE COST CENTERS				.1		
50. 00 51. 00	05000   OPERATING ROOM   05100   RECOVERY ROOM	7, 542	7, 542		0 0		50.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	850	,	1	-		
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 355	6, 355	1		2, 248, 984	1
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	3, 484	0 3, 484	1	0	0 2, 039, 714	56. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 464	3, 464				1
66.00	06600 PHYSI CAL THERAPY	370	370	827, 718	3 0	1, 170, 833	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1 .=.,		199, 098	
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	2, 857	2, 857	85, 398 503, 223		131, 292 899, 130	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,037	2,037	) 303, 22		1, 043, 042	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O		0	733, 633	
73. 00 76. 98	07300 DRUGS CHARGED TO PATIENTS	0	1		0 0		1
70. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0		1	0	0	76. 98
88. 00	08800 RHC - CASS ST	0	О	) (	0	1, 481, 650	88. 00
88. 01	08801 RHC - N. MANCHESTER	0	0		0	1, 362, 345	1
88. 02	08802   RHC - KI SSI NGER	114	[ 0 114	8, 876	0	607, 620 165, 403	1
	09001 SENI OR CARE	1, 009					
91.00	09100 EMERGENCY	5, 826					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVI CES	0	0		0	0	95. 00
	10100 HOME HEALTH AGENCY	Ö			0		101. 00
	SPECIAL PURPOSE COST CENTERS		·			·	1
	11300 INTEREST EXPENSE  11600 H0SPICE	0	_			0	113. 00 116. 00
118.00	1	75, 619	75, 619	13, 725, 762	-13, 748, 352		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	398					190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS	0	1	121, 769	9 0		
	19202 PV WABASH HEALTH CLINC-N. MANCH	Ö	Ö		o o	955, 370	
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	O		0	738, 185	
	07950 FITNESS CENTER	0	0		0		194.00
	07951   FOUNDATION   07952   NEW DIRECTION	258	258			236, 850 0	194. 01
	07953 COMMUNITY & VOLUNTEER SERVICES	Ö	Ö		o o		194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	O		0		194. 04
194. 05 200. 00	O7955  OCCUPATIONAL HEALTH   Cross Foot Adjustments	0	0		٥	0	194. 05 200. 00
200.00							201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 820, 011	1, 784, 033	4, 367, 04°	1	13, 748, 352	
202.00	Part I)	2/ 074/22	22 200405	0.21400		0.305700	202 22
203. 00 204. 00		36. 971629	23. 389485	0. 314990	ő	0. 395698 2, 137, 220	
_000	Part II)			1			55

Heal th Finar	ncial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019 To 12/31/2019		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00000	0	0. 061512	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

		PARKVIEW WABASH		ON 15 1010 5		Wardiahaat D. 1	
COST AL	LOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2019 To 12/31/2019		pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7. 00	8. 00	9. 00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
	00500 ADMINISTRATIVE & GENERAL						5. 00
	00700 OPERATION OF PLANT	46, 071	I I				7. 00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 668	1	44, 403			8. 00 9. 00
	01000 DI ETARY	1, 913	I .	1, 913			10.00
	01100 CAFETERI A	3, 415		3, 415		11, 138	1
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	147	l .	147		493 0	1
	01500 PHARMACY	2, 822	1	2, 822		795	
16. 00	01600 MEDICAL RECORDS & LIBRARY	C	l .	1		l .	1
	INPATIENT ROUTINE SERVICE COST CENTERS	6, 940			2 274	2 154	20.00
	03000  ADULTS & PEDI ATRI CS 04300  NURSERY	103		1			1
	ANCILLARY SERVICE COST CENTERS		,				]
	05000 OPERATING ROOM	7, 542	1	7, 542		,	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	850		1		0	
	05300 ANESTHESI OLOGY	030	1	030		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 355	0	6, 355	0	1, 629	54. 00
	05600 RADI OI SOTOPE	2 404	1	2 404	1	0	
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	3, 484		3, 484		0	
	06600 PHYSI CAL THERAPY	370	o	370	1	1, 317	
	06700 OCCUPATI ONAL THERAPY	C	0	(	_	126	
	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	2, 857	0	2, 857	_	102 787	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,837		2, 837	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	d	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	C	1				
	07698 HYPERBARIC OXYGEN THERAPY DUTPATIENT SERVICE COST CENTERS	C	jį	(	0	0	76. 98
88. 00	08800 RHC - CASS ST	C	0	C	0	0	88. 00
	08801 RHC - N. MANCHESTER	C	Ί ,	(	1	0	
	08802 RHC - KISSINGER 09000 CLINIC	114	΄Ι ΄	114		0 14	
	09001 SENI OR CARE	1, 009		1, 009		271	
	09100 EMERGENCY	5, 826	0	5, 826	0	1, 362	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		<u> </u>				92. 00
	09500 AMBULANCE SERVICES	С	0	(	0	0	95. 00
	10100 HOME HEALTH AGENCY		0	(	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			1			] 113. 00
	11600 HOSPI CE	0	0		0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	45, 415			3, 274		118. 00
	NONREI MBURSABLE COST CENTERS	200		1 200			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	398	1			•	190. 00 192. 00
	19201 PV WABASH HEALTH CLINC-CASS	Č	o o				192. 01
	19202 PV WABASH HEALTH CLINC-N. MANCH	C	0	C	0	<b>l</b>	192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER	C			0	<b>l</b>	192. 03 194. 00
	07930 TTTNE33 CENTER 07951 FOUNDATION	258	1	258	0		194. 00
194. 02	07952 NEW DIRECTION	C	0	C	0	<b>l</b>	194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES 07956 OTHER NONREIMBURSABLE COST CENTERS	C	0		0		194. 03 194. 04
	07935 OCCUPATIONAL HEALTH				0	•	194. 04
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0.40/.477		000 046	//5 705	4 404 000	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 196, 177		998, 348	665, 785	1, 181, 823	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	47. 669402	0. 000000	22. 48379 <i>6</i>	203. 355223	106. 107290	203. 00
204. 00	Cost to be allocated (per Wkst. B,	631, 108	0	164, 027	172, 171		
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	13. 698596	0. 000000	3. 694052	52. 587355	27. 568325	205. 00
206. 00		t l					206. 00
	(per Wkst. B-2)		1	l	1		

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDR)				
	7. 00	8. 00	9. 00	10.00	11. 00	
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Prepared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRS	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REV)	7/28/2020 4:40 pm
		1 NG HR) 13. 00	REQUI S. ) 14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	10.00		10.00	10.00	
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	116, 910				1. 0 2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0
	01400 CENTRAL SERVICES & SUPPLY	0	О			14. 0
	01500 PHARMACY	0	0	59, 688		15. 0
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	9, 999	16. 0
30. 00	03000 ADULTS & PEDIATRICS	50, 776	0	1, 200	757	30. 0
43.00	04300 NURSERY	2, 595	0	0	38	43. 0
	ANCILLARY SERVICE COST CENTERS		-1			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	22, 702	0	213 0	114	50. 0 51. 0
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 421	O	0	0	52. 0
53.00	05300 ANESTHESI OLOGY	0	0	83	0	53. 0
54. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	0	562 0	4, 068	54. 0 56. 0
60.00	06000 LABORATORY		0	62	0	60. 0
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63. 0
66.00	06600 PHYSI CAL THERAPY	0	0	3, 702	2, 127	66. 0
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	308 63	157 72	67. 0 68. 0
	06900 ELECTROCARDI OLOGY	0	Ö	0	0	69. 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	О	71. 0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0 E1 007	0	72.0
	07300 DRUGS CHARGED TO PATIENTS 07698 HYPERBARIC OXYGEN THERAPY	0	0	51, 897 0	0	73. 0 76. 9
	OUTPATIENT SERVICE COST CENTERS		-,	-	-	
88. 00	08800 RHC - CASS ST	0	0	0	0	88. 0
88. 01 88. 02	08801 RHC - N. MANCHESTER 08802 RHC - KISSINGER	0	0	0	0	88. 0   88. 0
	09000 CLI NI C	0	0	0	0	90. 0
90. 01	09001 SENI OR CARE	28, 416	0	0	0	90. 0
	09100 EMERGENCY	0	0	688	2, 666	91. 0
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92. 0
	09500 AMBULANCE SERVI CES	0	0	0	0	95. 0
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101. 0
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	1	1			113. 0
	11600 HOSPI CE	0	0	0	0	116. 0
118.00		116, 910	0	58, 778	9, 999	118. 0
100.00	NONREI MBURSABLE COST CENTERS		ol.			100.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	190. 0 192. 0
	19201 PV WABASH HEALTH CLINC-CASS	0	Ö	0	Ö	192. 0
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0	192. 0
	19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER	0	0	0	0	192. 0 194. 0
	07951 FOUNDATION		0	910	0	194. 0
194.02	07952 NEW DIRECTION	0	0	0	О	194. 0
	07953 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	194. 0
	07956 OTHER NONREIMBURSABLE COST CENTERS 07955 OCCUPATIONAL HEALTH	0	0	0	0	194. 0 194. 0
200.00			Ĭ	Ĭ	Ĭ	200. 0
201.00			1			201. 0
202. 00	71	1, 076, 037	0	2, 005, 985	0	202. 0
203.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	9. 203977	0. 000000	33. 607844	0. 000000	203. 0
	Cost to be allocated (per Wkst. B,	69, 685	0	317, 304	0	204. 0
204.00						
204.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 596057	0. 000000	5. 316043	0. 000000	205. 0

Health Fina	ncial Systems P	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 15-1310		Peri od:	Worksheet B-1	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT NRS	(COSTED		(GROSS REV)		
		ING HR)	REQUIS.)				
		13. 00	14. 00	15. 00	16.00		
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
COMPUTATION OF DATIO OF COSTS TO CHARGES	Dravi dan CCN, 1E 1210	Donind. Wankahaat C

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1310	Period: Worksheet C			
				From 01/01/2019	Part I		
				To 12/31/2019	Date/Time Pre 7/28/2020 4:4		
		Title	e XVIII	Hospi tal	Cost	U piii	
		11116	AVIII	Costs	0031		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs		
oust defited beschiption	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313		
	Part I, col.	7.09		21 041 1 01141100			
	26)						
	1. 00	2. 00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	6, 833, 144		6, 833, 14	4 0	0	30. 00	
43. 00   04300 NURSERY	177, 942		177, 94	.2 0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	4, 320, 502		4, 320, 50	0	0	50.00	
51.00   05100   RECOVERY ROOM	0			0 0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	906, 943		906, 94	.3 0	0	52.00	
53. 00   05300   ANESTHESI OLOGY	2, 789		2, 78	9 0	0	53.00	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 776, 463		3, 776, 46	3 0	0	54.00	
56. 00   05600   RADI 0I SOTOPE	0			0 0	0	56.00	
60. 00   06000   LABORATORY	3, 093, 323		3, 093, 32	3 0	0	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.00	
66. 00 06600 PHYSI CAL THERAPY	1, 924, 245	0	1, 924, 24	5 0	0	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	301, 602	0	301, 60	0	0	67.00	
68. 00 06800 SPEECH PATHOLOGY	196, 184	0	196, 18	4 0	0	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	1, 538, 847		1, 538, 84		0	69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 455, 772		1, 455, 77	2 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 023, 930		1, 023, 93	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 867, 779		6, 867, 77	9 0	0	73.00	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76. 98	
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RHC - CASS ST	2, 067, 936		2, 067, 93	6 0	0	88. 00	
88. 01   08801   RHC - N. MANCHESTER	1, 901, 422		1, 901, 42	2 0	0	88. 01	
88. 02   08802   RHC - KI SSI NGER	848, 054		848, 05	4 0	0	88. 02	
90. 00   09000   CLI NI C	240, 336		240, 33	6 0	0	90.00	
90. 01   09001   SENI OR CARE	916, 540		916, 54	.0	0	90. 01	
91. 00 09100 EMERGENCY	4, 987, 773		4, 987, 77	3 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 081, 695		2, 081, 69	5	0	92. 00	
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES	0			0 0		95. 00	
101.00 10100 HOME HEALTH AGENCY	0			0	0	101. 00	
SPECIAL PURPOSE COST CENTERS							
113. 00 11300 I NTEREST EXPENSE						113. 00	
116. 00 11600 HOSPI CE	0			0		116. 00	
200.00 Subtotal (see instructions)	45, 463, 221	0				200. 00	
201.00 Less Observation Beds	2, 081, 695		2, 081, 69			201. 00	
202.00 Total (see instructions)	43, 381, 526	0	43, 381, 52	6 0	0	202. 00	

Health Financial Systems	PARKVIEW WABASH H	HOSPITAL, INC.		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der CCN: 15-1310		Worksheet C Part I Date/Time Pre 7/28/2020 4:4	pared: O pm
			XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 196, 567		6, 196, 56			30. 00
43. 00 04300 NURSERY	218, 492		218, 49	2		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 802, 703	14, 242, 227	17, 044, 93		0. 000000	
51.00   05100   RECOVERY ROOM	0	0		0. 000000	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 045, 982	0	1,0,0,7		0. 000000	
53. 00   05300   ANESTHESI OLOGY	338, 399	2, 210, 669			0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 482, 481	27, 613, 558	29, 096, 03		0. 000000	
56. 00   05600   RADI 0I SOTOPE	0	0	1	0. 000000	0. 000000	
60. 00   06000   LABORATORY	2, 236, 099	16, 465, 077	18, 701, 17		0. 000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0.000000	0. 000000	63. 00
66. 00   06600 PHYSI CAL THERAPY	332, 965	4, 581, 259	4, 914, 22	0. 391566	0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	184, 911	308, 693	493, 60	0. 611020	0.000000	67. 00
68. 00   06800   SPEECH PATHOLOGY	60, 145	169, 654	229, 79	9 0. 853720	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 511, 980	4, 400, 031	5, 912, 01	1 0. 260292	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	720, 363	3, 153, 687	3, 874, 05	0. 375775	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	783, 858	4, 077, 725	4, 861, 58	0. 210617	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 183, 212	26, 192, 102	29, 375, 31	4 0. 233794	0.000000	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0.000000	0.000000	76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RHC - CASS ST	0	2, 088, 790	2, 088, 79	0		88. 00
88. 01   08801   RHC - N. MANCHESTER	0	1, 645, 804	1, 645, 80	14		88. 01
88. 02   08802   RHC - KI SSI NGER	0	694, 647	694, 64	.7		88. 02
90. 00  09000 CLI NI C	0	1, 137, 734	1, 137, 73	4 0. 211241	0. 000000	90.00
90. 01   09001   SENI OR CARE	0	932, 533	932, 53	0. 982850	0.000000	90. 01
91. 00   09100   EMERGENCY	957, 318	22, 030, 133	22, 987, 45	0. 216978	0. 000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 613, 113	2, 613, 11	3 0. 796634	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
200.00 Subtotal (see instructions)	22, 055, 475	134, 557, 436	156, 612, 91	1		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	22, 055, 475	134, 557, 436	156, 612, 91	1		202. 00

			To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 000000			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
60. 00   06000   LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RHC - CASS ST				88. 00
88. 01   08801   RHC - N. MANCHESTER				88. 01
88. 02   08802   RHC - KI SSI NGER				88. 02
90. 00  09000  CLI NI C	0. 000000			90.00
90. 01   09001   SENI OR CARE	0. 000000			90. 01
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			,

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.		In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1310	Peri od:	Worksheet C

Health Fina	ancial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-1310	Peri od:	Worksheet C	
					From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre	pared:
						7/28/2020 4: 4	0 pm
			liti	e XIX	Hospi tal	PPS	
			<b>-</b>	<del>-</del>	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	TIENT ROUTINE SERVICE COST CENTERS	1					
	OO ADULTS & PEDIATRICS	6, 833, 144		6, 833, 14		6, 833, 144	1
	00 NURSERY	177, 942		177, 94	12 0	177, 942	43. 00
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	4, 320, 502		4, 320, 50	0	4, 320, 502	50.00
	00 RECOVERY ROOM	0			0	0	51.00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	906, 943		906, 94	13 0	906, 943	52.00
53.00 0530	OO ANESTHESI OLOGY	2, 789		2, 78	39 0	2, 789	53. 00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	3, 776, 463		3, 776, 46	53 0	3, 776, 463	54.00
56. 00 0560	00 RADI OI SOTOPE	o			0 0	0	56. 00
60.00 0600	DO LABORATORY	3, 093, 323		3, 093, 32	23 0	3, 093, 323	60.00
	DO BLOOD STORING, PROCESSING & TRANS.	0			0	0	1
	00 PHYSI CAL THERAPY	1, 924, 245	0	1, 924, 24	15 0	1, 924, 245	
	00 OCCUPATIONAL THERAPY	301, 602	0	301, 60		301, 602	
	00 SPEECH PATHOLOGY	196, 184	0	196, 18		196, 184	1
	00 ELECTROCARDI OLOGY	1, 538, 847	O	1, 538, 84		1, 538, 847	1
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 455, 772		1, 455, 77		1, 455, 772	1
	OO IMPL. DEV. CHARGED TO PATIENTS	1, 023, 930		1, 023, 93		1, 023, 772	
	DO DRUGS CHARGED TO PATIENTS	6, 867, 779		6, 867, 77		6, 867, 779	
	28 HYPERBARI C OXYGEN THERAPY	0, 807, 779		0,007,7	0 0	0, 867, 779	1
		<u> </u>			0 0	U	70.90
	PATIENT SERVICE COST CENTERS OO RHC - CASS ST	2 0/7 02/		2.0/7.0		2.0(7.02(	00.00
		2, 067, 936		2, 067, 93		2, 067, 936	
	01 RHC - N. MANCHESTER	1, 901, 422		1, 901, 42		1, 901, 422	
	D2 RHC - KI SSI NGER	848, 054		848, 05		848, 054	1
	OO CLINIC	240, 336		240, 33		240, 336	1
	O1 SENI OR CARE	916, 540		916, 54		916, 540	
	DO EMERGENCY	4, 987, 773		4, 987, 77		4, 987, 773	
	OO OBSERVATION BEDS (NON-DISTINCT PART	2, 081, 695		2, 081, 69	95	2, 081, 695	92. 00
	R REIMBURSABLE COST CENTERS						
	00 AMBULANCE SERVICES	0			0 0	0	95. 00
101.00 1010	OO HOME HEALTH AGENCY	0			0	0	101. 00
	CLAL PURPOSE COST CENTERS						
113. 00 1130	00 INTEREST EXPENSE						113. 00
116. 00 1160	00 HOSPI CE				0	0	116. 00
200. 00	Subtotal (see instructions)	45, 463, 221	0	45, 463, 22	21 0	45, 463, 221	200.00
201. 00	Less Observation Beds	2, 081, 695		2, 081, 69		2, 081, 695	
202. 00	Total (see instructions)	43, 381, 526	0				
(			_		-		

ealth Financial Systems	PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF DATIO OF COCTS TO CHARGES		D 1 CON 15 1010	D!I	Wasaliaka a A

Health Financial Systems		PARKVIEW WABASH F	HOSPITAL, INC.		In Lieu of Form CMS-2552-10			
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der CCN: 1		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 7/28/2020 4:4	pared:	
			Ti tl	e XIX	Hospi tal	PPS	о рііі	
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio		
		6.00	7.00	8. 00	9. 00	10.00		
	IENT ROUTINE SERVICE COST CENTERS							
	ADULTS & PEDIATRICS	6, 196, 567		6, 196, 56			30. 00	
	NURSERY	218, 492		218, 49	92		43. 00	
	LARY SERVICE COST CENTERS			1				
	OPERATI NG ROOM	2, 802, 703	14, 242, 227			0. 000000		
	RECOVERY ROOM	0	0		0.000000	0. 000000		
	DELIVERY ROOM & LABOR ROOM	1, 045, 982	0 010 ((0	1, 045, 98		0.000000		
	ANESTHESI OLOGY	338, 399	2, 210, 669			0.000000		
	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	1, 482, 481	27, 613, 558			0.000000		
	LABORATORY	2, 236, 099	0 16, 465, 077	1	0.00000	0. 000000 0. 000000		
	BLOOD STORING, PROCESSING & TRANS.	2, 230, 099	10, 465, 077		0. 103408	0.00000		
	PHYSICAL THERAPY	332, 965	4, 581, 259	l .		0.00000	1	
	OCCUPATIONAL THERAPY	184, 911	308, 693			0.000000	1	
	SPEECH PATHOLOGY	60, 145	169, 654			0.000000		
	ELECTROCARDI OLOGY	1, 511, 980	4, 400, 031			0. 000000		
	MEDICAL SUPPLIES CHARGED TO PATIENT	720, 363	3, 153, 687			0. 000000		
	IMPL. DEV. CHARGED TO PATIENTS	783, 858	4, 077, 725			0. 000000		
	DRUGS CHARGED TO PATIENTS	3, 183, 212	26, 192, 102			0. 000000		
	HYPERBARI C OXYGEN THERAPY	0, 100, 212	0		0.000000	0. 000000		
	TIENT SERVICE COST CENTERS	<u> </u>			0.00000	0.00000	70.70	
	RHC - CASS ST	0	2, 088, 790	2, 088, 79	0. 990016	0. 000000	88. 00	
	RHC - N. MANCHESTER	0	1, 645, 804			0. 000000		
	RHC - KISSINGER	0	694, 647			0. 000000		
90.00 09000	CLINIC	0	1, 137, 734	1, 137, 73	0. 211241	0. 000000	90.00	
90. 01 09001	SENI OR CARE	0	932, 533			0. 000000		
91.00 09100	EMERGENCY	957, 318	22, 030, 133	22, 987, 45	0. 216978	0. 000000	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2, 613, 113	2, 613, 11	0. 796634	0. 000000	92.00	
OTHER	REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00	
	HOME HEALTH AGENCY	0	0		0		101. 00	
	AL PURPOSE COST CENTERS							
	INTEREST EXPENSE						113. 00	
116. 00 11600		0	0		0		116. 00	
200. 00	Subtotal (see instructions)	22, 055, 475	134, 557, 436	156, 612, 91	1		200. 00	
201. 00	Less Observation Beds						201. 00	
202. 00	Total (see instructions)	22, 055, 475	134, 557, 436	156, 612, 91	1		202. 00	

			To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000 OPERATI NG ROOM	0. 253477			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 867073			52.00
53. 00   05300   ANESTHESI OLOGY	0. 001094			53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 129793			54.00
56. 00   05600 RADI OI SOTOPE	0. 000000			56.00
60. 00   06000   LABORATORY	0. 165408			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
66. 00   06600 PHYSI CAL THERAPY	0. 391566			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 611020			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 853720			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 260292			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 375775			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210617			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 233794			73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
OUTPATIENT SERVICE COST CENTERS	<u> </u>			
88. 00 08800 RHC - CASS ST	0. 990016			88. 00
88. 01   08801   RHC - N. MANCHESTER	1. 155315			88. 01
88. 02   08802   RHC - KI SSI NGER	1. 220842			88. 02
90. 00   09000   CLI NI C	0. 211241			90.00
90. 01   09001   SENI OR CARE	0. 982850			90. 01
91. 00 09100 EMERGENCY	0. 216978			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 796634			92. 00
OTHER REIMBURSABLE COST CENTERS	<del></del>			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1

Heal th Financial Systems PARKVI EW WABA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1310

				1	0 12/31/2019	7/28/2020 4:4	pared: O nm
			Ti tl	e XIX	Hospi tal	PPS	o piii
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	•	(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		·		col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 320, 502	783, 561	3, 536, 941	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	C	0		0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	906, 943	105, 800			0	52.00
53.00	05300 ANESTHESI OLOGY	2, 789	441			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 776, 463	680, 363	3, 096, 100	0	0	54.00
56.00	05600  RADI 0I SOTOPE	0	C	0	0	0	56. 00
60.00	06000 LABORATORY	3, 093, 323	396, 691	2, 696, 632	0	0	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	1, 924, 245	156, 776		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	301, 602	17, 358			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	196, 184	11, 223	· ·		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 538, 847	299, 146	1, 239, 701	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 455, 772	64, 160			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 023, 930	45, 127	· ·		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 867, 779	501, 711	6, 366, 068	0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
	08800 RHC - CASS ST	2, 067, 936	91, 139			_	
	08801 RHC - N. MANCHESTER	1, 901, 422	83, 801			0	88. 01
	08802 RHC - KISSINGER	848, 054	37, 376			0	88. 02
90.00	09000 CLI NI C	240, 336	19, 424			0	90. 00
90. 01	09001 SENI OR CARE	916, 540	127, 343	· ·		0	90. 01
91. 00	09100 EMERGENCY	4, 987, 773	688, 622			0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 081, 695	319, 455	1, 762, 240	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	C				
101.00	10100 HOME HEALTH AGENCY	0	C	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300   INTEREST EXPENSE	_	_	_	_		113. 00
	11600 HOSPI CE	0	C	0	0		116. 00
200.00		38, 452, 135	4, 429, 517				200.00
201.00		2, 081, 695	319, 455				201. 00
202.00	Total (line 200 minus line 201)	36, 370, 440	4, 110, 062	32, 260, 378	0	0	202. 00

					10 12/31/2019	7/28/2020 4: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charg	je		
		Operating Cost	Part I, column	Ratio (col.	6		
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	4, 320, 502	17, 044, 930				50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	906, 943	1, 045, 982				52. 00
53.00	05300 ANESTHESI OLOGY	2, 789	2, 549, 068				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 776, 463	29, 096, 039	•			54.00
56. 00	05600  RADI 0I SOTOPE	0	0	0.00000			56. 00
60.00	06000 LABORATORY	3, 093, 323	18, 701, 176				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000			63. 00
66. 00	06600 PHYSI CAL THERAPY	1, 924, 245	4, 914, 224				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	301, 602	493, 604				67. 00
68. 00	06800 SPEECH PATHOLOGY	196, 184	229, 799				68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 538, 847	5, 912, 011				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 455, 772	3, 874, 050	0. 37577	'5		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 023, 930	4, 861, 583				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 867, 779	29, 375, 314				73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	00		76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RHC - CASS ST	2, 067, 936	2, 088, 790				88. 00
88. 01	08801 RHC - N. MANCHESTER	1, 901, 422	1, 645, 804				88. 01
88. 02	08802 RHC - KISSINGER	848, 054	694, 647				88. 02
90.00	09000 CLI NI C	240, 336	1, 137, 734				90.00
90. 01	09001 SENI OR CARE	916, 540	932, 533	0. 98285	0		90. 01
91. 00	09100 EMERGENCY	4, 987, 773	22, 987, 451		8		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 081, 695	2, 613, 113	0. 79663	34		92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0				95. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0.00000	00		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	0	0.00000	00		116. 00
200.00		38, 452, 135	150, 197, 852				200. 00
201.00		2, 081, 695	0				201. 00
202.00	Total (line 200 minus line 201)	36, 370, 440	150, 197, 852				202. 00

Health Financial Systems	PARKVIEW WABASH HOSE	PI TAL	_, IN	C.	 In Lie	u of Form (	CMS-2552-10
		_					

Health Financial Systems	PARKVI EW WABASH	RKVIEW WABASH HOSPITAL, INC.  L COSTS  Provider CCN: 15-1310  Period:  Worksheet				
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS		Provi der CCN: 15-1310		Worksheet D Part II Date/Time Pre 7/28/2020 4:4	pared: O pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T		1			
50. 00   05000   OPERATI NG ROOM	783, 561	17, 044, 930				
51. 00   05100   RECOVERY   ROOM	0	1	0.00000		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	105, 800		1		0	52. 00
53. 00 05300 ANESTHESI OLOGY	441	2, 549, 068		•	•	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	680, 363	29, 096, 039				
56. 00   05600   RADI 0I SOTOPE	0	0	0.00000		0	56. 00
60. 00   06000   LABORATORY	396, 691	18, 701, 176		•	16, 914	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
66. 00 06600 PHYSI CAL THERAPY	156, 776			•		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	17, 358					
68.00 06800 SPEECH PATHOLOGY	11, 223			•		
69. 00   06900   ELECTROCARDI OLOGY	299, 146					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64, 160	3, 874, 050		•		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	45, 127					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	501, 711	29, 375, 314			20, 008	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C	0.00000	0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RHC - CASS ST	91, 139		1		0	88. 00
88.01   08801   RHC - N. MANCHESTER	83, 801	1, 645, 804			0	88. 01
88. 02   08802   RHC - KI SSI NGER	37, 376	694, 647	0.05380	6 0	0	88. 02
90. 00  09000 CLI NI C	19, 424	1, 137, 734			0	90.00
90. 01  09001   SENI OR CARE	127, 343	932, 533			0	90. 01
91. 00   09100   EMERGENCY	688, 622			6 42, 210	1, 264	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	319, 455	2, 613, 113	0. 12225	1 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	4, 429, 517	150, 197, 852		5, 092, 307	144, 444	200. 00

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: Heal th Financial Systems PARKVIEW WABASH HOST APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1310 THROUGH COSTS

				'	12/31/2017	7/28/2020 4: 4	
				XVIII	Hospi tal	Cost	
	Cost Center Description			Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	0	0	50. 00
	05100 RECOVERY ROOM	0	0	(	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	(	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54. 00
	05600 RADI 0I SOTOPE	0	0	(	0	0	56. 00
	06000 LABORATORY	0	0	(	0	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0	0	63. 00
	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
	08800 RHC - CASS ST	0	0	(	0	0	88. 00
	08801 RHC - N. MANCHESTER	0	0	(	0	0	88. 01
	08802 RHC - KISSINGER	0	0	(	0	0	88. 02
	09000 CLI NI C	0	0	(	0	0	90. 00
	09001 SENI OR CARE	0	0	(	0	0	90. 01
	09100 EMERGENCY	0	0	(	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(	)	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	,					
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Heal th	Financial Systems P	ARKVIEW WABASH	HOSPITAI INC		In lie	eu of Form CMS-2	2552_10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER COSTS				Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV	pared:
			Ti tl e	: XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	)	0 17, 044, 930		
	05100 RECOVERY ROOM	0	0	1	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 1, 045, 982	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0 2, 549, 068	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 29, 096, 039	0.000000	54.00
56.00	05600 RADI OI SOTOPE	0	0	)	0 0	0.000000	56. 00
60.00	06000 LABORATORY	0	0	)	0 18, 701, 176	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	)	0 0	0.000000	63.00
66.00	06600 PHYSI CAL THERAPY	0	0	)	0 4, 914, 224	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	)	0 493, 604	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	)	0 229, 799	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	O	0	)	0 5, 912, 011	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	)	0 3, 874, 050	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 4, 861, 583	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 29, 375, 314	0.000000	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.000000	76. 98
	OUTPATIENT SERVICE COST CENTERS				•		1
88 00	08800 RHC - CASS ST	0	0		0 2 088 790	0.000000	88 00

0

2, 088, 790 1, 645, 804

694, 647 1, 137, 734 932, 533

22, 987, 451

150, 197, 852

2, 613, 113

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0.000000

0. 000000 0. 000000

0.000000

88.00

88.01

88. 02

90.00

90. 01 91. 00

92. 00 95. 00

200. 00

08800 RHC - CASS ST 08801 RHC - N. MANCHESTER 08802 RHC - KISSINGER

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

09000 CLINIC 09001 SENIOR CARE

95. 00 09500 AMBULANCE SERVICES

91. 00 09100 EMERGENCY

88.00

88. 01

88. 02

90.00

90. 01

200.00

Health Financial Systems	PARKVIEW WABASH HO	SPITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	

THROUGH	1 COSTS				From 01/01/2019 To 12/31/2019	Date/Time Pre	
				20011		7/28/2020 4: 4	0 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	•	Costs (col. 9	
		7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
	O5000 OPERATING ROOM	0. 000000	842, 754	I ,		0	50.00
	05100 RECOVERY ROOM	0. 000000	842, 754		0	1	51.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0	1	51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0.000000	106, 845		0	1	53.00
	05300  ANESTHESTOLOGY 05400  RADI OLOGY-DI AGNOSTI C	0.000000	464, 660	1	0	1	54.00
	05600 RADI OLOGY-DI AGNOSTI C	0.000000	464, 660		0	1	56.00
	06000 LABORATORY	0.000000	U 707 277		0	1	60.00
			797, 377		0	1	63.00
	06300 BL00D STORING, PROCESSING & TRANS. 06600 PHYSICAL THERAPY	0.000000	1F7 140		0	1	66.00
	06700 OCCUPATIONAL THERAPY	0. 000000 0. 000000	156, 148		0	1	67.00
	06800 SPEECH PATHOLOGY	0.000000	85, 564		0	1	68.00
	06900  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	0.000000	27, 724		0		69.00
		0. 000000	792, 035		0		71.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	218, 686		0		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	386, 834		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 171, 470	1	0	0	73.00
+	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0. 000000	0	1	0 0	0	76. 98
	08800 RHC - CASS ST	0. 000000	0		0	0	88. 00
	08801 RHC - 0. MANCHESTER	0.000000	0			1	88. 01
	08802 RHC - KISSINGER	0. 000000	0			1	88. 02
	09000 CLINIC	0. 000000	0			1	90.00
	09001 SENI OR CARE	0. 000000	0			1	90.00
	09100 EMERGENCY	0.000000	42, 210			1	91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	42, 210	i		0	92.00
L .	OTHER REIMBURSABLE COST CENTERS	0.000000	0	'I'	<u>J</u> 0	U	1 /2.00
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		5, 092, 307		0	0	200. 00
					1		

Health Financial Systems	PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS-2552-10

alth Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu o					u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019	Part V	
				To 12/31/2019		pared:
		T: 41 -		11: 4-1	7/28/2020 4: 4	U pm
		IIIIE	XVIII	Hospi tal	Cost	
		550 5 1 1	Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Servi ces (see	Rei mbursed	Rei mbursed	(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 OPERATING ROOM	0. 253477	0	1	0 2, 971, 555	0	50. 00
51.00   05100   RECOVERY ROOM	0. 000000	l .		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 867073	0	1	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 001094	0		0 460, 286	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 129793	0	)	0 8, 326, 332	0	54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000	0	1	0 0	0	56.00
60. 00 06000 LABORATORY	0. 165408	0	)	0 4, 964, 224	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	)	o o	0	63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 391566	l o	)	0 1, 503, 264	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 611020	0	)	0 69, 410	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 853720	l o	)	0 41, 487	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 260292		)	0 1, 541, 072	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 375775		,	0 505, 600	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210617	0	,	0 1, 033, 238	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 233794	0	1	0 12, 147, 695	0	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 12,117,070	0	76. 98
OUTPATIENT SERVICE COST CENTERS	0.00000		1	9  9		70.70
88. 00 08800 RHC - CASS ST	0. 000000				0	88. 00
88. 01   08801   RHC - N. MANCHESTER	0. 000000				0	88. 01
88. 02   08802   RHC - KI SSI NGER	0. 000000				0	88. 02
90. 00   09000   CLI NI C	0. 211241	0			0	90.00
90. 01   09001   SENI OR CARE	0. 982850	0		0 609, 678	0	90. 01
91. 00 09100 EMERGENCY	0. 216978			0 4, 643, 285	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 796634	0		0 629, 824	0	92. 00
OTHER REIMBURSABLE COST CENTERS	0. 770034		1	027,024	0	72.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			0		95. 00
200.00 Subtotal (see instructions)		0	,	0 39, 446, 950	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program		]		0 0	ŭ	201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		О .		0 39, 446, 950	0	202. 00

				10 12/31/2019	Date/lime Pre   7/28/2020 4:4	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						4
50.00 05000 OPERATING ROOM	0	753, 221				50. 00
51.00 05100 RECOVERY ROOM	0	0				51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
53. 00   05300   ANESTHESI OLOGY	0	504				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	1, 080, 700				54.00
56. 00   05600   RADI 0I SOTOPE	0	0				56. 00
60. 00   06000   LABORATORY	0	821, 122				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
66. 00   06600   PHYSI CAL THERAPY	0	588, 627				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	42, 411				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	35, 418				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	401, 129				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	189, 992				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	217, 617				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 840, 058				73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RHC - CASS ST	0	0				88. 00
88. 01   08801   RHC - N. MANCHESTER	0	0				88. 01
88. 02   08802   RHC - KI SSI NGER	0	0				88. 02
90. 00  09000   CLI NI C	0	0				90.00
90. 01  09001   SENI OR CARE	0	599, 222				90. 01
91. 00   09100   EMERGENCY	0	1, 007, 491				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	501, 739				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	0	9, 079, 251				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	9, 079, 251				202. 00
	•	•				•

Health Finan	cial Systems		PARKVIEW WABASH HOS	SPITAL, INC.	Ir	n Lieu of Form CMS-2552-10
A DDODTI ONMEN	T OF MEDICAL	OTHER HEALTH CERVICES	AND VACCINE COCT	Descriden CCN, 1E 1210	Doni od.	Waskahaat D

Peri od: From 01/01/2019 To 12/31/2019 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1310 Worksheet D Part V Component CCN: 15-Z310 Date/Time Prepared: 7/28/2020 4:40 pm Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 253477 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.867073 0 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.001094 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 129793 0 54.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 0 0 0 0 0 0 56 00 0 06000 LABORATORY 60.00 0.165408 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 06600 PHYSI CAL THERAPY 0 66.00 0.391566 0 66.00 0 06700 OCCUPATIONAL THERAPY 67 00 0.611020 67 00 68.00 06800 SPEECH PATHOLOGY 0.853720 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 260292 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.375775 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0.210617 Ω 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 233794 C 0 0 0 73.00 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76. 98 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RHC - CASS ST 0.000000 88.00 0 88. 01 08801 RHC - N. MANCHESTER 0.000000 0 88.01 08802 RHC - KISSINGER 0.000000 88.02 88.02 09000 CLI NI C 90.00 90.00 0.211241 0 0 0 0 09001 SENI OR CARE 0 90.01 90.01 0.982850 Ω 0 91.00 09100 EMERGENCY 0. 216978 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 0. 796634 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 200.00 Subtotal (see instructions) 0 0 200. 00 0 0 0 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges

0

0

0 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PARKVIEW WABASH HO	SPITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1310 Component CCN: 15-Z310	From 01/01/2019	Worksheet D Part V Date/Time Prepared: 7/28/2020 4:40 pm

		Component	CCN: 15-Z310	To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm
		Title	XVIII	Swing Beds - SNF	
	Cos	its			
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM	0	0			50. 00
51. 00   05100   RECOVERY ROOM	0	0			51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0			54. 00
56. 00   05600   RADI 0I SOTOPE	0	0			56. 00
60. 00   06000   LABORATORY	0	0			60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63. 00
66. 00  06600 PHYSI CAL THERAPY	0	0			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			76. 98
OUTPATIENT SERVICE COST CENTERS					
88. 00   08800   RHC - CASS ST	0	0			88. 00
88. 01   08801   RHC - N. MANCHESTER	0	0			88. 01
88. 02   08802   RHC - KI SSI NGER	0	0			88. 02
90. 00   09000   CLI NI C	0	0			90.00
90. 01  09001   SENI OR CARE	0	0			90. 01
91. 00   09100   EMERGENCY	0	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0				95. 00
200.00 Subtotal (see instructions)	0	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00   Net Charges (line 200 - line 201)	0	0			202. 00

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2019		
				To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	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 & PEDI ATRI CS	1, 048, 606	C	1, 048, 60	6 4, 707	222. 78	30. 00
43. 00 NURSERY	16, 026		16, 02	6 159	100. 79	43. 00
200.00 Total (lines 30 through 199)	1, 064, 632		1, 064, 63	2 4, 866		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 ADULTS & PEDI ATRI CS	85	18, 936				30. 00
43. 00 NURSERY	88	8, 870				43.00
200.00 Total (lines 30 through 199)	173	27, 806				200. 00

Health Financial Sy	ystems	PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF I	NDATIENT ANOLILIADY CEDVICE	CARLEAL COCTO	D 1 1 00N 4E 404	0 0 1	W I I I D

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Health Financial Systems F	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
Capital Charges (From Wkst. B, Part II, col.   Capital Charges (From Wkst. C, Part II, col.   Charges (From Wkst. C, Part II, col.   Charges (Col. 1 + col.   Charges (Co	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			From 01/01/2019	Part II Date/Time Pre	
Related Cost (From Wisst, C.) and (From Wisst, C.							
Cfrom Wisst. B, Part II, col.   26)   Recovery   Reco	Cost Center Description						
Part II, col.   8)   2)							
ANCI LLARY SERVI CE COST CENTERS					. Charges	column 4)	
1.00   2.00   3.00   4.00   5.00			8)	2)			
ANCI LLARY SERVICE COST CENTERS							
50.00		1.00	2. 00	3. 00	4. 00	5. 00	
51.00         05100         RECOVERY ROOM         0         0         0.000000         0         0         51.00           52.00         05200         DELI LYERY ROOM & LABOR ROOM         105,800         1,045,982         0.101149         30,802         3,116         52.00           53.00         05300         ANSTHESI OLOGY         441         2,549,068         0.00000         39,051         7         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         680,363         29,096,039         0.023383         64,828         1,516         54.00           56.00         05600         RADI OLOGY-DI AGNOSTI C         680,363         29,096,039         0.023383         64,828         1,516         54.00           66.00         05600         RADI OLOGY-DI AGNOSTI C         680,363         29,096,039         0.023383         64,828         1,516         54.00           60.00         05000         DASTORIA TORY         396,691         18,701,716         0.021212         97,991         2,079         0.02           63.00         DASTORIA THERAPY         156,776         4,914,224         0.031902         7,268         232         66.00           67.00         DASTORIT TORATI ONAL THERAPY         17,358 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
S2. 00   05200   DELIVERY ROOM & LABOR ROOM   105,800   1,045,982   0.101149   30,802   3,116   52.00   53.00   05300   ANESTHESI DLOGY   441   2,549,068   0.000173   39,051   7   53.00   63.00		783, 561	17, 044, 930				
53.00         05300         ANESTHESI OLOGY         441         2,549,068         0.000173         39,051         7         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         680,363         29,096,039         0.23383         64,828         1,516         54.00           65.00         05600         RADI OLOGY-DI AGNOSTI C         0.0000000         0.000000         0.000000         0.000000         0.000000         0.0000000         0.0000000         0.0000000         0.0000000         0.0000000         0.0000000         0.0000000         0.0000		0	0			1	
54.00         05400         RADI OLOGY-DI AGNOSTI C         680, 363         29, 096, 039         0.023383         64, 828         1, 516         54.00           56.00         05600         RADI OI SOTOPE         0         0.00000         0.000000         0         0.56.00           60.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0         0.000000         0.000000         0         0.33.00           66.00         06600         PHYSI CAL THERAPY         156, 776         4, 914, 224         0.031902         7, 268         232         66.00           67.00         06700         OCCUPATI ONAL THERAPY         17, 358         493, 604         0.035166         5, 656         199         67.00           68.00         06800         SPEECH PATHOLOGY         11, 223         229, 799         0.048838         1, 252         61         188, 00           69.00         06900         ELECTROCARDI OLOGY         299, 146         5, 912, 011         0.050600         29, 020         1, 468         69, 00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         45, 127         4, 861, 583         0.009282         0         0         72.00           73.00         O7300         INPL. DEV. C		•					
56.00   05600   RADI OI SOTOPE   0   0   0   0   0   0   0   0   0		1		1		•	
60. 00   06000   LABORATORY   396, 691   18, 701, 176   0. 021212   97, 991   2, 079   60. 00   63.00   66. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0. 0000000   0   0   63.00   66. 00   06600   PHYSI CAL THERAPY   156, 776   4, 914, 224   0. 031902   7, 268   232   66. 00   67. 00   06700   00CUPATI ONAL THERAPY   17, 358   493, 604   0. 035166   5, 656   199   67. 00   68. 00   06800   SPEECH PATHOLOGY   11, 223   229, 799   0. 048838   1, 252   61   68. 00   69. 00   06900   ELECTROCARDI OLOGY   299, 146   5, 912, 011   0. 050600   29, 020   1, 468   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   64, 160   3, 874, 050   0. 016561   15, 743   261   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   45, 127   4, 861, 583   0. 009282   0   0   0   72. 00   07409   HYPERBARI C DAYGEN THERAPY   0   0   0. 000000   0   0   0   76. 98   00000000   0   0   0   0   0   0   0		680, 363	29, 096, 039			1, 516	
63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0.000000   0   0   63. 00   66. 00   06600   PHYSI CAL THERAPY   156, 776   4, 914, 224   0.031902   7, 268   232   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   17, 358   493, 604   0.035166   5, 656   199   67. 00   68. 00   06800   SPEECH PATHOLOGY   11, 223   229, 799   0.048838   1, 252   61   68. 00   69. 00   06900   ELECTROCARDI OLOGY   299, 146   5, 912, 011   0.050600   29, 020   1, 468   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   64, 160   3, 874, 050   0.016561   15, 743   261   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   45, 127   4, 861, 583   0.009282   0   0.72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   501, 711   29, 375, 314   0.017079   121, 850   2, 081   73. 00   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0.000000   0   0   0   76. 98   00TPATI ENT SERVICE COST CENTERS   76. 98   08800   RHC - CASS ST   91, 139   2, 088, 790   0.043632   0   0   88. 01   77. 00   09000   CLI NI C   19, 424   1, 137, 734   0.017073   0   0   0   79. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   90. 00   79. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   90. 01   79. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   319, 461   2, 613, 113   0.122253   0   0   70. 00   09500   AMBULANCE SERVI CES   95. 00   75. 00   09500   AMBULANCE SERVI CES   75. 00   75. 00   75. 00   09500   AMBULANCE SERVI CES   75. 00   75. 00   75. 00   09500   AMBULANCE SERVI CES   75. 00   75. 00   75. 00   75. 00   00000   00000   0000000   0000000   000000		0	0	1			
66. 00   06600   PHYSI CAL THERAPY   156, 776   4, 914, 224   0. 031902   7, 268   232   66. 00   6700   0CCUPATI ONAL THERAPY   17, 358   493, 604   0. 035166   5, 656   199   67. 00   6800   SPEECH PATHOLOGY   11, 223   229, 799   0. 048838   1, 252   61   68. 00   6800   SPEECH PATHOLOGY   299, 146   5, 912, 011   0. 050600   29, 020   1, 468   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   64, 160   3, 874, 050   0. 016561   15, 743   261   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   45, 127   4, 861, 583   0. 009282   0   0   72. 00   73.00   DRUGS CHARGED TO PATI ENTS   501, 711   29, 375, 314   0. 017079   121, 850   2, 081   73. 00   76. 98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0. 000000   0   0   0   0   0		396, 691	18, 701, 176			2, 079	
67. 00 06700 OCCUPATIONAL THERAPY 17, 358 493, 604 0.035166 5, 656 199 67. 00 68. 00 06800 SPEECH PATHOLOGY 11, 223 229, 799 0.048838 1, 252 61 68. 00 69. 00 06900 ELECTROCARDIOLOGY 299, 146 5, 912, 011 0.0506000 29, 020 1, 468 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 64, 160 3, 874, 050 0.016561 15, 743 261 71. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 45, 127 4, 861, 583 0.009282 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 501, 711 29, 375, 314 0.017079 121, 850 2, 081 73. 00 07409 IMPL. SERVICE COST CENTERS 501, 711 29, 375, 314 0.017079 121, 850 2, 081 73. 00 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
68. 00		•		l .			
69. 00							
71. 00		11, 223	229, 799			61	
72. 00		299, 146	5, 912, 011	0. 05060	29, 020	1, 468	69. 00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	64, 160	3, 874, 050	0. 01656	15, 743	261	71. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY O O O 0.000000 O O O 76. 98 OUTPATI ENT SERVI CE COST CENTERS  88. 00 08800 RHC - CASS ST 91, 139 2, 088, 790 0.043632 O 0 88. 00 88. 01 08801 RHC - N. MANCHESTER 83, 801 1, 645, 804 0.050918 O 0 88. 01 88. 02 08802 RHC - KI SSI NGER 37, 376 694, 647 0.053806 O 0 88. 02 90. 00 09000 CLI NI C 19, 424 1, 137, 734 0.017073 O 0 90. 00 90. 01 09001 SENI OR CARE 127, 343 932, 533 0.136556 O 0 90. 01 91. 00 09100 EMERGENCY 688, 622 22, 987, 451 0.029956 63, 242 1, 894 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 319, 461 2, 613, 113 0.12253 O 92. 00 OTHER REI MBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	45, 127	4, 861, 583	0.00928	32 0	0	72. 00
S8. 00   08800 RHC - CASS ST   91, 139   2, 088, 790   0. 043632   0   0   88. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	501, 711	29, 375, 314	0. 01707	79 121, 850	2, 081	73. 00
88. 00   08800   RHC - CASS ST   91, 139   2, 088, 790   0.043632   0   0   88. 00   88. 01   08801   RHC - N. MANCHESTER   83, 801   1, 645, 804   0.050918   0   0   88. 01   88. 02   08802   RHC - KI SSI NGER   37, 376   694, 647   0.053806   0   0   0   88. 02   09000   CLI NI C   19, 424   1, 137, 734   0.017073   0   0   90. 00   90. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   0   90. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   0   90. 01   09001   09		0	0	0.00000	0 0	0	76. 98
88. 01   08801   RHC - N. MANCHESTER   83, 801   1, 645, 804   0.050918   0   0   88. 01   88. 02   08802   RHC - KI SSI NGER   37, 376   694, 647   0.053806   0   0   0   88. 02   09000   CLI NI C   19, 424   1, 137, 734   0.017073   0   0   90. 00   90. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   90. 01   09100   EMERGENCY   688, 622   22, 987, 451   0.029956   63, 242   1, 894   91. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART   319, 461   2, 613, 113   0.122253   0   0   92. 00   09500   AMBULANCE SERVI CES   95. 00							
88. 02   08802   RHC - KISSINGER   37, 376   694, 647   0.053806   0   0   88. 02   90. 00   09000   CLINIC   19, 424   1, 137, 734   0.017073   0   0   90. 00   90. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   90. 01   91. 00   09100   EMERGENCY   688, 622   22, 987, 451   0.029956   63, 242   1, 894   91. 00   92. 00   09200   OSSERVATI ON BEDS (NON-DI STINCT PART   319, 461   2, 613, 113   0.12253   0   0   95. 00   OTHER REI MBURSABLE COST CENTERS   95. 00						0	
90. 00   09000   CLI NI C   19, 424   1, 137, 734   0. 017073   0   0   90. 00   90. 01   90.	88. 01   08801   RHC - N. MANCHESTER	83, 801	1, 645, 804	0. 05091	8 0	0	88. 01
90. 01   09001   SENI OR CARE   127, 343   932, 533   0.136556   0   0   90. 01   91. 00   99. 001   99. 0	88. 02   08802   RHC - KI SSI NGER	37, 376	694, 647	0. 05380	06	0	88. 02
91. 00   09100   EMERGENCY   688, 622   22, 987, 451   0. 029956   63, 242   1, 894   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   319, 461   2, 613, 113   0. 122253   0   0   92. 00   000	90. 00  09000  CLI NI C	19, 424	1, 137, 734	0. 01707	'3 0	0	90. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   319, 461   2, 613, 113   0.122253   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   95. 00   00   00   00   00   00   00   00	90. 01  09001 SENLOR CARE	127, 343	932, 533	0. 13655	66 0	0	90. 01
OTHER REIMBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVICES   95. 00	91. 00   09100   EMERGENCY	688, 622	22, 987, 451	0. 02995	63, 242	1, 894	91.00
OTHER REIMBURSABLE COST CENTERS         95. 00           95. 00         O9500 AMBULANCE SERVICES         95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	319, 461	2, 613 <u>,</u> 113	0. 12225	0	0	92.00
200.00   Total (lines 50 through 199)   4,429,523   150,197,852   569,068   17,160 200.00	95. 00  09500 AMBULANCE SERVICES						95. 00
	200.00   Total (lines 50 through 199)	4, 429, 523	150, 197, 852		569, 068	17, 160	200. 00

	PARKVIEW WABASH			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COST			Period: From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 43. 00   04300   NURSERY	0	0		0 0	0	43. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0	0	4, 70 15 4, 86	9 0.00	85 88 173	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0 0					30. 00 43. 00 200. 00

Provider CCN: 15-1310 THROUGH COSTS

					0 12/31/2019	7/28/2020 4:4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School		Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	0	0	
	05100 RECOVERY ROOM	0	0	(	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	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	63.00
66. 00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
	08800  RHC - CASS ST	0	0	(	0	0	00.00
	08801 RHC - N. MANCHESTER	0	0	(	0	0	88. 01
	08802 RHC - KI SSI NGER	0	0	(	0	0	88. 02
90.00	09000  CLI NI C	0	0	(	0	0	90.00
90. 01	09001 SENI OR CARE	0	0	(	0	0	90. 01
91.00	09100 EMERGENCY	0	0	(	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(	)	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	() C	0	0	200. 00

Heal th	Financial Sys	stems		PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTI	ONMENT OF IN	PATI ENT/OUTPATI ENT	ANCILLARY SE	RVICE OTHER PASS	Provider Co		Peri od:	Worksheet D	
THROUGH	1 COSTS						From 01/01/2019		
						-	To 12/31/2019		
								7/28/2020 4: 4	0 pm
					Titl	e XIX	Hospi tal	PPS	
	Cost Ce	nter Description		All Other	Total Cost	Total	Total Charges	Ratio of Cost	
				Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
				Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
					4)	col s. 2, 3,	8)	7)	
						and 4)		(see	
								inatruational	

			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	·	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	ANOLULARY OFRICASE ASST. OFFITTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_			17.011.000		
	05000 OPERATI NG ROOM	0	0		17, 044, 930	0.000000	
	05100 RECOVERY ROOM	0	0		0	0.000000	1
	05200 DELIVERY ROOM & LABOR ROOM	0	0		1, 045, 982	0. 000000	1
	05300 ANESTHESI OLOGY	0	0		2, 549, 068		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		29, 096, 039		l
	05600 RADI OI SOTOPE	0	0		0	0. 000000	l
	06000 LABORATORY	0	0	C	18, 701, 176		1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0. 000000	1
	06600 PHYSI CAL THERAPY	0	0	C	4, 914, 224	0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0	C	493, 604	0. 000000	
	06800 SPEECH PATHOLOGY	0	0	C	229, 799		1
	06900 ELECTROCARDI OLOGY	0	0	C	5, 912, 011	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	3, 874, 050		1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	4, 861, 583		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	C	29, 375, 314		1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	<u> </u>	0	0. 000000	76. 98
	OUTPATIENT SERVICE COST CENTERS	_	_	_			
	08800 RHC - CASS ST	0	0	C	2, 088, 790		
	08801 RHC - N. MANCHESTER	0	0	C	1, 645, 804	0. 000000	
	08802 RHC - KISSINGER	0	0	C	694, 647	0. 000000	1
	09000 CLI NI C	0	0	C	1, 137, 734	0. 000000	1
	09001 SENI OR CARE	0	0	C	932, 533		1
	09100 EMERGENCY	0	0	C	22, 987, 451	0. 000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	<u> </u>	2, 613, 113	0. 000000	92. 00
05.0-	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	_	_	_	450 407 555		95. 00
200.00	Total (lines 50 through 199)	0	0	C	150, 197, 852		200. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	F ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od: From 01/01/2019	Worksheet D Part IV Date/Time Prepared:

THROUG	IN CUSTS				o 12/31/2019	Date/Time Pre 7/28/2020 4:4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0. 000000	92, 365	(	0	0	00.00
51. 00	05100 RECOVERY ROOM	0. 000000	0	(	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	30, 802		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	39, 051		0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	64, 828	(	0	0	54. 00
56. 00	05600  RADI OI SOTOPE	0. 000000	0	(	0	0	56. 00
60.00	06000 LABORATORY	0. 000000	97, 991	(	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	(	0	0	63. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	7, 268	(	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 656		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1, 252	(	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	29, 020	(	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	15, 743		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	121, 850	C	0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	C	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RHC - CASS ST	0. 000000	0	C	0	0	88. 00
88. 01	08801 RHC - N. MANCHESTER	0. 000000	0	C	0	0	88. 01
88. 02	08802 RHC - KISSINGER	0. 000000	0	C	0	0	88. 02
90.00	09000 CLI NI C	0. 000000	0	C	0	0	90.00
90. 01	09001 SENI OR CARE	0. 000000	0	C	0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	63, 242	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	C	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		569, 068	(	o	0	200. 00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2019	Part V	
				To 12/31/2019	Date/Time Pre	
		Ti +I	e XIX	Hospi tal	7/28/2020 4: 4 PPS	U pili
		11 (1	Charges	nospi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
oost center bescription		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(300 11.01.)	
	Part I, col. 9	, , ,	Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 253477	0		0 94, 472	0	50.00
51.00   05100   RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 867073	0		0 0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 001094	0		0 9, 994	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 129793	0		0 454, 859	0	54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
60. 00   06000   LABORATORY	0. 165408	0		0 347, 606	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. 391566	0		0 30, 958	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 611020	0		0 1, 476	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 853720	0		0 17, 585	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 260292	0		0 14, 309	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 375775	0		0 41, 168	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 210617	0		0 2, 525	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 233794	0		0 510, 623	0	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RHC - CASS ST	0. 990016				0	88. 00
88. 01   08801   RHC - N. MANCHESTER	1. 155315				0	88. 01
88. 02   08802   RHC - KI SSI NGER	1. 220842				0	88. 02
90. 00  09000   CLI NI C	0. 211241	0		0 0	0	90. 00
90. 01   09001   SENI OR CARE	0. 982850	0		0 0	0	90. 01
91. 00   09100   EMERGENCY	0. 216978	0		0 553, 780	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 796634	0		0 34, 635	0	92. 00
OTHER REIMBURSABLE COST CENTERS	,					
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
200.00 Subtotal (see instructions)		0		0 2, 113, 990	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0	1	0 2, 113, 990	0	202. 00

Health Financial Systems	PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1310	Peri od:	Worksheet D

From 01/01/2019 | Part V To 12/31/2019 | Date/Time Prepared: 7/28/2020 4:40 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 946 50.00 51.00 05100 RECOVERY ROOM 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 11 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 59, 038 54.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 56.00 Ω 06000 LABORATORY 60.00 57, 497 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06600 PHYSI CAL THERAPY 66.00 12, 122 66.00 06700 OCCUPATIONAL THERAPY 902 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 15,013 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 725 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 470 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 532 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 119, 381 73.00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RHC - CASS ST 0 0 0 0 0 0 88.00 0 88. 01 08801 RHC - N. MANCHESTER 0 88.01 88. 02 08802 RHC - KISSINGER 0 88.02 90.00 09000 CLI NI C 0 90.00 09001 SENI OR CARE 90.01 90.01 0 91.00 09100 EMERGENCY 120, 158 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 27, 591 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0 95.00 09500 AMBULANCE SERVICES 200.00 Subtotal (see instructions) 0 455, 386 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 202.00 455, 386

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	From 01/01/2019		
		To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm	
	Title XVIII	Hospi tal	Cost	

		Ti +Lo VVIII	Hospi tal	7/28/2020 4: 4	0 pm
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	oost deliter bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 708 4, 707	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		ivate room days	4, 707	1
3.00	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			3, 273	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period	om daya) after Dasambar	21 of the cost	0	6. 00
6.00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	olli days) ai tei beceilibei	of the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	1	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	1, 327	9. 00
7. 00	newborn days) (see instructions)	The fregram (exertaining	Swifing Dear and	1,027	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instruct				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (excluding swing-bed	uays)	0	15.00
16.00	Nursery days (title V or XIX only)			0	ı
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	arter becomber or or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	137. 32	19. 00
20.00	reporting period	o often December 21 of t	ha aaat	127 22	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	safter becember 31 of t	ne cost	137. 32	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		6, 833, 144	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	21 of the cost respectin	a nominal (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	137	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			137	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		6, 833, 007	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	1
29. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	ł
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	ı
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	35. 00 36. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 833, 007	36.00
37.00	27 minus line 36)			5, 555, 567	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 451. 67	1
40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 926, 366 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		1, 926, 366	ł
		,			•

		PARKVIEW WABASH F				eu of Form CMS-	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-1310	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			Title	: XVIII	Hospi tal	7/28/2020 4: 4 Cost	0 pm
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.	00 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	S					43.00
44. 00	CORONARY CARE UNIT						44.00
45.00	I control of the cont						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description						17.00
40.00	December 1 and 1 a	l-+ D 21 2	1: 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (W Total Program inpatient costs (sum of lines			ns)		1, 195, 884 3, 122, 250	1
17.00	PASS THROUGH COST ADJUSTMENTS	TT thi ough 10) (	see mistractro	113)		0, 122, 200	17.00
50.00	Pass through costs applicable to Program in	patient routine s	services (from	Wkst. D, su	m of Parts I and	0	50.00
51. 00		natient ancillary	/ services (fr	om Wkst D	sum of Parts II	0	51.00
	and IV)		, , , , , , , , , , , , , , , , , ,				
52.00	Total Program excludable cost (sum of lines				L-4:-4	0	
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		ateu, non-phy	sician anest	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					1
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions)	operting period	anding 1004 u	ndatad and a	omnounded by the	0.00	
39.00	Lesser of lines 53/54 or 55 from the cost r market basket	eportring perrou t	endring 1996, u	puateu anu c	ollipourided by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of lin which operating costs (line 53) are less th					0	61.00
	amount (line 56), otherwise enter zero (see		3 (TITIES 54 X	00), 01 1% 0	the target		
62.00	Relief payment (see instructions)		-+!>			0	
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see mstruc	etrons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine co	sts through Decer	mber 31 of the	cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decemba	er 31 of the c	ost reportin	a neriod (See	0	65.00
00.00	instructions)(title XVIII only)	Sta di tel Becomb	51 01 01 110 0	ost reportin	g perrou (see		00.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost r	eporting period	0	67. 00
	(line 12 x line 19)	-				_	
68. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	ecember 31 of	the cost rep	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER				)		70.00
70. 00 71. 00	Skilled nursing facility/other nursing faciladjusted general inpatient routine service				)		70.00
72. 00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
7/ 00	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 min	us line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce			*.	nus Lino 70)		79.00
80.00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ost iiiiii täti ON	(11116 / Ø IIII)	nus IIIle /9)		80.00
82. 00	Inpatient routine service cost limitation (	line 9 x line 81)					82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i		s)				83.00
85. 00	Utilization review - physician compensation		ns)				85.00
86. 00	Total Program inpatient operating costs (su	m of lines 83 thr					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PARTOTAL Observation bed days (see instruction					1, 434	   87. 00
88. 00	,	•	line 2)			1, 451. 67	
	Observation bed cost (line 87 x line 88) (s	aa instructions)				2, 081, 695	1 00 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 CC		Period: From 01/01/2019	Worksheet D-1	
				Fo 12/31/2019	Date/Time Prep 7/28/2020 4:40	pared: O pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 048, 606	6, 833, 144	0. 153459	2, 081, 695	319, 455	90.00
91.00 Nursing School cost	0	6, 833, 144	0.000000	2, 081, 695	0	91.00
92.00 Allied health cost	0	6, 833, 144	0. 000000	2, 081, 695	0	92.00
93.00 All other Medical Education	0	6, 833, 144	0. 000000	2, 081, 695	0	93. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2019	Worksheet D-1	
			Date/Time Pre 7/28/2020 4:4	
	Title XIX	Hospi tal	PPS	U pili
Cost Center Description				

		Title XIX	Hospi tal	77 287 2020 4: 41 PPS	о рііі
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 708 4, 707	1. 00 2. 00
2. 00 3. 00					
0.00	do not complete this line.	s). It you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be			3, 273	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	m days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	m davs) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	1	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	davs) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	85	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private ro	nom days)	0	10.00
.0.00	through December 31 of the cost reporting period (see instruct	i ons)	,	· ·	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	only (merdaring private	o room days)	· ·	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(exer daring suring bed to	14,57	159	15. 00
16. 00	Nursery days (title V or XIX only)			88	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	s through Docombon 21 of	f the cost		17. 00
17.00	reporting period	s through becember 31 of	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of 1	the cost		18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	tili dugir becelliber 31 di	the cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	)		6, 833, 144	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe	r 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
	x line 18)		, , ,		
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ line 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		6, 833, 144	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation had cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed en	11 903)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us line 33)(see instruct	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		11 0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost dif	ferential (line	6, 833, 144	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	i nstructi ons)		1, 451. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		123, 395	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 123, 395	40.00
41.00	Trotal Trogram general impatrent routine service cost (ITHE 39	11116 40)	l	123, 393	41.00

COMITOT	ATION OF INPATIENT OPERATING COST		Provider CC	CN: 15-1310	Peri od: From 01/01/2019	Worksheet D-1	nored.
					To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	177, 942	159	1, 119.	13 88	98, 483	42.00
40.00	Intensive Care Type Inpatient Hospital Units						1 40 00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
40.00	Drogram innetient engilleny complete engt (Wille	2+ D 2 and 2	Line 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ns)		137, 836 359, 714	
47.00	PASS THROUGH COST ADJUSTMENTS	+1 till ough 40) (3	ee mstructro	113)		337, 714	47.00
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and	27, 806	50.00
	111)						
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	17, 160	51.00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				44, 966	52. 00
53. 00	Total Program inpatient operating cost excluding		ated, non-phy	sician anesti	netist, and	314, 748	
	medical education costs (line 49 minus line !						
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operati	ing cost and tare	net amount (L	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing coot and tan	got amount (i			0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep	oorting period e	ndi ng 1996, u	pdated and co	ompounded by the	0. 00	59.00
(0.00	market basket		_ 4 _ 4			0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see i		•	, .	3		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	her 31 of the	cost reporti	ng period (See	0	64. 00
01.00	instructions) (title XVIII only)	to the ough boom	00. 0. 0. 0.	300 t . 3po. t.	g po ou (000	· ·	011 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the c	ost reporting	g period (See	0	65.00
// 00	instructions)(title XVIII only)	+- (1: (	4	E) (+: +1 - )(///	III.O F	0	
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (Time o	4 prus rine o	b)(title XVII	ii oniy). Foi	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	eporting period	0	67.00
	(line 12 x line 19)	J			. 31		
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (1)	ine 67 + line	68)		0	69. 00
37.00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	, 57.00
70. 00	Skilled nursing facility/other nursing facili				)		70.00
71.00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line		(II: 44 II:	25)			72.00
73. 00 74. 00	Medically necessary private room cost applications Total Program general inpatient routine servi			ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		orksheet B. I	Part II, column		75.00
	26, line 45)			,			
76. 00	Per diem capital-related costs (line 75 ÷ lin	. *					76.00
77. 00	Program capital -related costs (line 9 x line						77. 00 78. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			79.00
80. 00	Total Program routine service costs for compa			•	nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi			-	,		81.00
82.00	Inpatient routine service cost limitation (li	· · · · · · · · · · · · · · · · · · ·					82.00
83.00	Reasonable inpatient routine service costs (		)				83.00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		5)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	Total observation bed days (see instructions)	·				1, 434	

1, 434 87. 00 1, 451. 70 88. 00 2, 081, 738 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Prep 7/28/2020 4:40	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 048, 606	6, 833, 144	0. 15345	9 2, 081, 738	319, 461	90. 00
91.00 Nursing School cost	0	6, 833, 144	0.00000	2, 081, 738	0	91. 00
92.00 Allied health cost	0	6, 833, 144	0.00000	2, 081, 738	0	92. 00
93.00 All other Medical Education	0	6, 833, 144	0. 000000	2, 081, 738	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-1310	Peri od: From 01/01/2019 To 12/31/2019		pared:
	Ti tl e	· XVIII	Hospi tal	Cost	•
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•		•	
30. 00 03000 ADULTS & PEDIATRICS			2, 275, 565		30.0
43. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 25347			
51. 00   05100   RECOVERY ROOM		0. 00000		0	
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 86707		0	
53. 00   05300   ANESTHESI OLOGY		0. 00109			53. C
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 12979			
56. 00   05600   RADI 0I SOTOPE		0. 00000		0	
60. 00   06000   LABORATORY		0. 16540		131, 893	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.0
66. 00   06600   PHYSI CAL THERAPY		0. 39156			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 61102			
68. 00 06800 SPEECH PATHOLOGY		0. 85372			
69. 00 06900 ELECTROCARDI OLOGY		0. 26029			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 37577			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21061			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23379			
76. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS		0. 00000	00 0	0	76. 9
88. 00   08800   RHC - CASS ST		0.00000	<b>10</b>	0	88. 0
88. 01   08800   RHC - CASS ST		0.00000		0	
88. 02   08802   RHC - KISSI NGER		0.00000		0	1
90. 00   09000   CLI NI C		0. 21124		0	1
90. 01   09001 SENI OR CARE		0. 21124		0	1
91. 00   09100   EMERGENCY		0. 21697		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 79663			
OTHER REIMBURSABLE COST CENTERS		0.77000	· ·1		1 /2.
95. 00 09500 AMBULANCE SERVI CES					95. 0
200.00 Total (sum of lines 50 through 94 and 96 th	rough 98)		5, 092, 307	1, 195, 884	

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

1, 195, 884 200. 00 201. 00 202. 00

5, 092, 307 0 5, 092, 307

200. 00 201. 00

202.00

	Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	ON 15 1010		eu of Form CMS-:	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1310	Peri od: From 01/01/2019	Worksheet D-3	
		Component	CCN: 15-Z310	To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
		Ti tl e	XVIII	Swing Beds - SNI		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	LNDATLENT POLITINE CERVILOE OCCT OFNITERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1		\	30.00
	04300 NURSERY				<b>'</b>	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 2534	77 C	0	50.00
51. 00	05100 RECOVERY ROOM		0.0000			
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 8670		ol o	52.00
53. 00	05300 ANESTHESI OLOGY		0. 0010			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1297		ol o	
56. 00	05600 RADI OI SOTOPE		0.0000		0	1
60.00	06000 LABORATORY		0. 1654	08	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00 0	0	63.00
66.00	06600 PHYSI CAL THERAPY		0. 3915	66 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 6110	20 C	0	67. 00
	06800 SPEECH PATHOLOGY		0. 8537		0	
	06900 ELECTROCARDI OLOGY		0. 2602		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3757		0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2106		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2337		1	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.0000	00 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS		1		_	
	08800 RHC - CASS ST		0.0000		0	
88. 01	08801 RHC - N. MANCHESTER		0.0000		0	
88. 02	08802 RHC - KI SSI NGER		0.0000		0	
90.00	09000 CLINIC		0. 2112		0	90.00
90. 01 91. 00	09001 SENI OR CARE 09100 EMERGENCY		0. 9828 0. 2169		0	90. 01
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2169			
72. UU	OTHER REIMBIRSARIE COST CENTERS		J U. 1900	34	<u> </u>	72.00

95.00

0 200. 00 201. 00 202. 00

0 0

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00

202.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form	CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT  Provider CCN: 15-1310   Period:   Workshee   From 01/01/2019	t D-3
To 12/31/2019 Date/Tim	e Prepared: 0 4:40 pm
	PPS
Cost Center Description Ratio of Cost   Inpatient   Inpatie	
To Charges   Program   Program	
Charges (col. 1 x	COI.
2)	
1.00 2.00 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.00
30. 00   03000   ADULTS & PEDI ATRI CS   179, 744   43. 00   04300   NURSERY   13. 156	30.00
	43. 00
ANCI LLARY   SERVI CE   COST   CENTERS	3, 412 50. 00
51. 00   05100  RECOVERY ROOM	0 51.00
	5, 708 52.00
53. 00   05300  ANESTHESI OLOGY	43 53.00
	3, 414 54. 00
56. 00   05600  RADI 01 SOTOPE   0. 000000   0	0 56.00
	6, 208 60. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0.000000   0	0 63.00
	2, 846 66. 00
	3, 456 67. 00
68. 00   06800   SPEECH PATHOLOGY   0. 853720   1, 252	, 069 68. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 260292   29, 020	7, 554 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.375775 15,743	5, 916 71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0.210617 0	0 72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 233794   121, 850   2	3, 488 73. 00
76. 98   07698   HYPERBARI C   0XYGEN   THERAPY   0. 000000   0	0 76. 98
OUTPATIENT SERVICE COST CENTERS	
88. 00   08800   RHC - CASS ST   0. 990016   0	0 88.00
88. 01   08801   RHC - N. MANCHESTER   1. 155315   0	0 88. 01
88. 02   08802   RHC - KI SSI NGER 1. 220842 0	0 88. 02
90. 00   09000   CLI NI C   0. 211241   0	0 90.00
90. 01   09001   SENI OR CARE 0. 982850 0	0 90. 01
91. 00   09100   EMERGENCY	3, 722 91. 00

0. 216978 0. 796634

569, 068

569, 068

0

137, 836 200. 00 201. 00 202. 00

92. 00

95.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

92.00

200. 00 201. 00

202.00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 7/28/2020 4:40 pm

			10 12/31/2017	7/28/2020 4: 4	
		Title XVIII	Hospi tal	Cost	<u> </u>
			<u> </u>		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9, 079, 251	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	
3.00	OPPS payments	0			
4.00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	1
6. 00	Line 2 times line 5			0	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
10. 00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 079, 251	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
40.00	Reasonable charges				
12. 00	Ancillary service charges			0	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
45.00	Customary charges				45.00
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		n a cnargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(6	=)		0.000000	17 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
	Total customary charges (see instructions)	vifling 10 avecade lie	. 11) (000	0	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y II ITHE 18 exceeds ITH	ie II) (See	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds lin	20 10) (600	0	20.00
20.00	instructions)	y II IIIle II exceeds III	ie 10) (see		20.00
21. 00	Lesser of cost or charges (see instructions)			9, 170, 044	21. 00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instr	ructions)		o o	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4011 0113)		Ö	1
21.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				21.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	:)		73, 952	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	6, 801, 614	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•	,	2, 294, 478	1
27.00	instructions)	2. 40 2.10 24 2	a.ia 20] (000	2,2,1,1,0	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	•		0	1
30.00	Subtotal (sum of lines 27 through 29)			2, 294, 478	30.00
31.00	Primary payer payments			115	31.00
32.00	Subtotal (line 30 minus line 31)			2, 294, 363	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			890, 560	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			578, 864	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		792, 641	36. 00
37. 00	Subtotal (see instructions)			2, 873, 227	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00	Subtotal (see instructions)			2, 873, 227	1
40. 01	Sequestration adjustment (see instructions)			57, 465	
40. 02	Demonstration payment adjustment amount after sequestration			0	
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			4, 302, 826	1
	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			-1, 487, 064	1
43. 01	Balance due provider/program-PARHM (see instructions)			_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	cnapter 1,	0	44. 00
	§115. 2				1
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)			0	1
/ <del>4</del> . 00	rotar (Sum or Titles /1 and 75)			ı	1 /4.00

Health Financial Systems PARKVIE ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1310

				10 12/31/2019	7/28/2020 4: 40	
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
	<u> </u>					
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Takal interior as marks and to analyte a	1. 00	2.00	3. 00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		2, 629, 76	0	3, 750, 126 0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for			U .	ا	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					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			05 (00 (0010	104.000	
3. 01	ADJUSTMENTS TO PROVIDER			0 05/29/2019	104, 800	3. 01
3. 02 3. 03				0 07/30/2019	447, 900 0	3. 02 3. 03
3. 03				0		3. 03
3.04				0		3. 04
3.03	Provider to Program			<u> </u>	U	3. 03
3.50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51				Ö	0	3. 51
3.52				o	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	552, 700	3. 99
	3. 50-3. 98)		0 /00 7/			
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 629, 76	6	4, 302, 826	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			ol	0	5. 50
5. 50 5. 51	ILINIATIVE TO PROGRAM			0		5. 50 5. 51
5. 51				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		69, 21	6	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	1, 487, 064	6. 02
7.00	Total Medicare program liability (see instructions)		2, 698, 98		2, 815, 762	7. 00
				Contractor	NPR Date	
		,	)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
5. 55	1			T	1	5. 55

In Lieu of Form CMS-2552-10 Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1310 Peri od: Worksheet E-1 From 01/01/2019 To 12/31/2019 Part I Component CCN: 15-Z310 Date/Time Prepared: 7/28/2020 4:40 pm Title XVIII Swing Beds - SNF Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1. 00 0 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.50-3.98) 0 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program

3.00 3.03 3.50 3.99 4.00 5.00 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 0 0 6.01 6 02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00 8.00 Name of Contractor 8.00

Heal th	Financial Systems PARKVIEW WABA	SH HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1310	Peri od:	Worksheet E-1	
			From 01/01/2019		
			To 12/31/2019		
		T: +1 o V/// / /	Hooni tol	7/28/2020 4: 4	U pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COURTED BY CONTRACTOR FOR MONOTANDARD COOT REPORT			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
1. 00	Total hospital discharges as defined in AARA §4102 from		14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	00			5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2. Pt. I		7.00
	line 168	33			
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8. 00
9.00	Sequestration adjustment amount (see instructions)	•			9. 00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE I PPS & CAH	(200 111011 4011 6110)			
30.00	Initial/interim HIT payment adjustment (see instructions	)			30.00
31. 00	Other Adjustment (specify)	,			31. 00
	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	s)		32.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1310	Peri od:	Worksheet E-2
			From 01/01/2019	

Component CCN: 15-Z310 | To 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm Title XVIII Swing Beds - SNF Cost Part A Part B 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) О 0 1.00 Inpatient routine services - swing bed-NF (see instructions) 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, 0 Ω 3.00 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see 3.01 Nursing and allied health payment-PARHM (see instructions) 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5.00 Program days 0 Λ 5.00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 7.00 0 0 0 8 00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 0 8 00 Primary payer payments (see instructions) 9.00 0 9.00 10.00 Subtotal (line 8 minus line 9) 0 10.00 0 Deductibles billed to program patients (exclude amounts applicable to physician 0 11.00 11.00 professional services) 12 00 Subtotal (line 10 minus line 11) 0 0 12 00 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 0 0 13.00 for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (see instructions) 0 0 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 0 16.55 16.55 adjustment (see instructions) 16.99  ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 0 0 0 0 0 0 16.99 Ω 17.00 Allowable bad debts (see instructions) 0 17.00 17.01 17.01 Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 18.00 0 19.00 Total (see instructions) Ω 19 00 19. 01 Sequestration adjustment (see instructions) 19.01 0 19. 02 Demonstration payment adjustment amount after sequestration) 19.02 19.03 Sequestration adjustment-PARHM pass-throughs 19 03 20.00 Interim payments 0 20.00 Interim payments-PARHM 20. 01 20.01 Tentative settlement (for contractor use only) 21.00 21.00 0 0 Tentative settlement-PARHM (for contractor use only) 21 01 21 01 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 22.00 22 01 Balance due provider/program-PARHM (see instructions) 22.01 0 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 23.00 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200.00 Is this the first year of the current 5-year demonstration period under the 21st 200.00 Century Cures Act? Enter "Y" for yes or "N" for no Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 201. 00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202. 00 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 203.00

204.00 Medicare swing-bed SNF discharges (see instructions) 204.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration

peri od) 205.00 Medicare swing-bed SNF target amount 205.00 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206. 00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00

207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208. 00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209 00 210.00 Reserved for future use 210.00

215.00

Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)

Health Financial Systems	PARKVIEW WABASH HOSPI	TAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN: 15-1310	From 01/01/2019	Worksheet E-3 Part V Date/Time Prepared: 7/28/2020 4:40 pm
		Ti +1 o V/// / /	Hocni tal	Coct

Title XVIII   Hospital   Cost					7/28/2020 4:4	O pm
PART V - CALCILATION OF REMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REMBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCILATION OF REMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REMBURSEMENT						
1.00					1. 00	
2.00   Nursing and Allied Health Managed Care payment (see instructions)   0 2.00   0.00		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
3.00   Organ ácquisition   3.102,250   4.00   5.00   Frimary payer payments   0.5.00   5.00   Frimary payer payments   0.5.00   5.00   7.00	1.00	Inpatient services			3, 122, 250	1.00
Subtotal (sum of lines 1 through 3)   3, 122, 250   4 00	2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
Subtotal (sum of lines 1 through 3)   3, 122, 250   4, 00	3.00	Organ acquisition			0	3.00
Primary payer payments	4.00	Subtotal (sum of lines 1 through 3)			3, 122, 250	4.00
Total cost (Line 4 less line 5). For CAH (see instructions)   3,153,473   6.00	5.00					5.00
COMPUTATION OF LESSER OF COST OR CHARGES	6.00				3, 153, 473	6.00
Reasonable charges						
8.00   Ancillary service charges   0   8.00   0   0.00						
8.00   Ancillary service charges   0   8.00   0   0.00   Total reasonable charges   0   9.00   0.00   Total reasonable charges   0   0.00   0.00   Total reasonable charges   0   0.00	7.00	Routi ne servi ce charges			0	7.00
9, 00   Organ acquisition charges, net of revenue   0   9, 00   10, 00   Total reasonable charges   0   10, 00   Total reasonable charges   0   10, 00   1	8.00	Ancillary service charges			0	1
10. 00   Total reasonable charges	9.00				0	9. 00
Customary charges	10.00				0	10.00
12.00   Amounts that would have been realized from patients   Iable for payment for services on a charge basis   0   12.00						
12.00   Amounts that would have been realized from patients   Iable for payment for services on a charge basis   0   12.00	11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11. 00
had such payment been made in accordance with 42 CFR 413.13(e)	12.00				0	12. 00
14. 00   Total customary charges (see instructions)   0   14. 00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see   0   15. 00   15. 00   Excess of customary charges (complete only if line 6 exceeds line 14) (see   0   16. 00   16.				3		
14. 00   Total customary charges (see instructions)   0   14. 00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see   0   15. 00   15. 00   Excess of customary charges (complete only if line 6 exceeds line 14) (see   0   16. 00   16.	13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13. 00
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   0   16.00	14.00	Total customary charges (see instructions)				
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   17.00   17.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   19.0	15.00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15. 00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)		instructions)		, ,		
17. 00	16.00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds line	e 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   18. 00   Direct graduate medical education payments (from Worksheet E-4, line 49)   0. 18. 00   0. 19. 00   0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		instructions)				
18.00       Direct graduate medical education payments (from Worksheet E-4, line 49)       0       18.00         19.00       Cost of covered services (sum of lines 6, 17 and 18)       3,153,473       19.00         20.00       Deductibles (excl ude professional component)       407,692       20.00         21.00       Excess reasonable cost (from line 16)       0       21.00         22.00       Subtotal (line 19 minus line 20 and 21)       2,745,781       22.00         24.00       Subtotal (line 22 minus line 23)       2,742,712       24.00         25.00       All owable bad debts (exclude bad debts for professional services) (see instructions)       17,463       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       11,351       26.00       20.00         27.00       All owable bad debts for dual eligible beneficiaries (see instructions)       10,637       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       2,754,063       28.00         29.00       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.99       Pioneer ACO demonstration payment adjustment sequestration       2,754,063       30.00         30.01       Sequestration adjustment amount after sequestration       55,081       30.01         30.02<	17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 All lowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 All owable bad debts (exclude bad debts (see instructions) 27.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Subtotal (see instructions) 30.03 Sequestration adjustment (see instructions) 30.03 Sequestration adjustment (see instructions) 30.03 Sequestration adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 30.03 Sequestration adjustment (see instructions) 30.03 Sequestration adjustment (see instructions) 31.00 Interim payments 32.01 Tentative settlement (for contractor use only) 33.01 Balance due provider/program (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 31.00 Square (solution of the sex of the secondance with CMS Pub. 15-2, chapter 1, 31.00 Square (solution of the sex of the secondance with CMS Pub. 15-2, chapter 1, 31.00 Square (solution of the sex of the secondance with CMS Pub. 15-2, chapter 1, 31.00 Square (solution of the sex of the secondance with CMS Pub. 15-2, chapter 1, 31.00 Square (solution of the sex of the secondance with CMS Pub. 15-2, chapter 1,		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
20. 00       Deductibles (exclude professional component)       407, 692       20. 00         21. 00       Excess reasonable cost (from line 16)       0 21. 00         22. 00       Subtotal (line 19 minus line 20 and 21)       2, 745, 781       22. 00         24. 00       Subtotal (line 22 minus line 23)       3, 069       23. 00         25. 00       Al lowable bad debts (exclude bad debts for professional services) (see instructions)       17, 463       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       11, 351       26. 00         27. 00       Al lowable bad debts for dual eligible beneficiaries (see instructions)       10, 637       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       2, 754, 063       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0 29. 50         29. 90       Subtotal (see instructions)       2, 754, 063       30. 00         30. 01       Sequestration adjustment (see instructions)       55, 081       30. 01         30. 02       Sequestration adjustment amount after sequestration       0 20. 00         31. 00       Interim payments       2, 629, 766       31. 00         31. 01	18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
21. 00 Excess reasonable cost (from line 16)	19. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 153, 473	19. 00
22.00       Subtotal (line 19 minus line 20 and 21)       2,745,781       22.00         23.00       Coinsurance       3,069       23.00         24.00       Subtotal (line 22 minus line 23)       2,742,712       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       17,463       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       11,351       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       10,637       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       2,754,063       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.90       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.90       Subtotal (see instructions)       0       29.99         30.01       Sequestration adjustment (see instructions)       2,754,063       30.00         30.02       Demonstration payment adjustment amount after sequestration       55,081       30.01         31.01       Interim payments       2,629,766       31.00         31.01       Interim payments       2,629,766       31.00         31.01       Tenta	20.00	Deductibles (exclude professional component)			407, 692	20. 00
23. 00   Coinsurance   3, 069   23. 00   24. 00   25. 00   All lowable bad debts (exclude bad debts for professional services) (see instructions)   17, 463   25. 00   27. 00   Adjusted reimbursable bad debts (see instructions)   11, 351   26. 00   27. 00   Adjusted reimbursable bad debts (see instructions)   10, 637   27. 00   28. 00   Subtotal (sum of lines 24 and 25, or line 26)   27. 54, 063   28. 00   29. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   07. 00   07.	21.00	Excess reasonable cost (from line 16)			0	21. 00
24. 00       Subtotal (line 22 minus line 23)       2, 742, 712       24. 00         25. 00       Al lowable bad debts (exclude bad debts for professional services) (see instructions)       17, 463       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       11, 351       26. 00         27. 00       Al lowable bad debts for dual eligible beneficiaries (see instructions)       2, 754, 063       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       2, 754, 063       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 50         29. 99       Demonstration payment adjustment amount before sequestration       0       27. 54, 063       30. 00         30. 01       Sequestration adjustment (see instructions)       55, 081       30. 00         30. 02       Demonstration payment adjustment amount after sequestration       0       2, 754, 063       30. 00         31. 01       Interim payments       2, 629, 766       31. 00         31. 01       Interim payments       2, 629, 766       31. 00         31. 01       Interim payments       2, 629, 766       31. 00         32. 01       Tentative s	22. 00	Subtotal (line 19 minus line 20 and 21)			2, 745, 781	22. 00
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  26. 00 Adjusted reimbursable bad debts (see instructions)  27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pioneer ACO demonstration payment adjustment (see instructions)  29. 90 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  117, 463 25. 00  11, 351 26. 00  2, 754, 063 28. 00  2, 754, 063 28. 00  2, 754, 063 30. 00  29. 90  29. 90  20. 754, 063 30. 00  20. 755, 063 30. 00  30. 02  30. 03 Sequestration adjustment for sequestration  30. 02 Sequestration adjustment payment amount after sequestration  30. 02 Sequestration adjustment amount after sequestration  30. 03 Sequestration adjustment (see instructions)  31. 01 Interim payments  117, 463 25. 00  11, 351 26. 00  2, 754, 063 32. 00  29. 90  29. 90  29. 90  29. 90  29. 90  20. 754, 063 30. 00  20. 92, 90  20. 754, 063 30. 00  20. 02  20. 03  20. 03  20. 03  20. 03  20. 04  20. 05  20. 05  20. 06  20. 06  20. 07  20. 07  20. 08  20. 07  20. 08  20.	23.00	Coinsurance			3, 069	23. 00
26. 00 Adj usted reimbursable bad debts (see instructions)  27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  97. 00 Demonstration payment adjustment (see instructions)  29. 99 Demonstration payment adjustment amount before sequestration  29. 99 Demonstration payment adjustment amount before sequestration  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment amount after sequestration  30. 03 Interim payments  111, 351 26. 00  2, 754, 063 28. 00  2, 754, 063 28. 00  2, 99. 00  2, 99. 00  2, 99. 00  2, 754, 063 30. 00  30. 01  30. 02 Subtotal (see instructions)  55, 081 30. 01  30. 02 Sequestration adjustment amount after sequestration  30. 02 Sequestration adjustment amount after sequestration  31. 01 Interim payments  11, 351 26. 00  2, 754, 063 28. 00  2, 754, 063 28. 00  2, 754, 063 30. 00  2, 754, 063 30. 00  30. 01  30. 02 29. 99  2, 754, 063 30. 00  30. 02 30. 03  30. 01  30. 02 30. 02  30. 03  30. 03  31. 01 Interim payments -PARHM  31. 01  32. 00  32. 01  33. 01  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	24.00	Subtotal (line 22 minus line 23)			2, 742, 712	24. 00
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 90 Demonstration payment adjustment amount before sequestration  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment amount after sequestration  31. 00 Interim payments  31. 01 Interim payments  31. 01 Tentative settlement (for contractor use only)  32. 01 Tentative settlement (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  30. 02 27. 00  2, 754, 063 28. 00  2, 754, 063 30. 00  29. 99  2, 754, 063 30. 00  39. 01  30. 02  39. 02  39. 03  30. 03  30. 04  30. 05  30. 07  30. 02  30. 02  30. 02  30. 02  30. 02  30. 02  30. 03  31. 01  32. 04  33. 07  34. 00  34. 00	25.00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		17, 463	25. 00
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	26.00	Adjusted reimbursable bad debts (see instructions)			11, 351	26. 00
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Bemonstration payment adjustment amount after sequestration  30. 02 Sequestration adjustment -PARHM  31. 00 Interim payments  31. 01 Interim payments  32. 629, 766  31. 00  32. 00 Tentative settlement (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		10, 637	27. 00
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  31. 01 Interim payments  32. 629, 766  31. 00  32. 00 Tentative settlement (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31. 01, and 32. 01)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	28. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 754, 063	28. 00
29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 04 Sequestration adjustment -PARHM 30. 05 Sequestration adjustment -PARHM 31. 00 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement -PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 29. 99 2, 754, 063 30. 00 30. 02 30. 03 30.	29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.00 Spanna 30.0	29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
30. 01 Sequestration adjustment (see instructions) 55,081 30. 01 30. 02 Demonstration payment adjustment amount after sequestration 0 30. 02 30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments 2,629,766 31. 00 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 69, 216 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00	29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.02 Demonstration payment adjustment amount after sequestration  30.02 30.03 Sequestration adjustment-PARHM  31.00 Interim payments  1.01 Interim payments-PARHM  32.00 Tentative settlement (for contractor use only)  32.01 Tentative settlement-PARHM (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30.00	Subtotal (see instructions)			2, 754, 063	30.00
30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments 2, 629, 766 31. 00 31. 01 Interim payments-PARHM 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 69, 216 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00	30. 01	Sequestration adjustment (see instructions)			55, 081	30. 01
31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	30. 03	Sequestration adjustment-PARHM				30. 03
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31.00	Interim payments			2, 629, 766	31.00
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	31. 01	Interim payments-PARHM				31. 01
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	32.00	Tentative settlement (for contractor use only)			0	32. 00
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2, 31, and 32)		69, 216	33. 00
	33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	inus lines 30.03, 31.01,	and 32.01)		33. 01
§115. 2	34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
		<b> §115. 2</b>				

Health Financial Systems PARKVIEW WABA
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-1310

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm

oni y)				10 12/01/201/	7/28/2020 4: 4	O pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	1 040 040				1
1.00	Cash on hand in banks Temporary investments	349, 849			0	
2. 00 3. 00	Notes receivable	0			0	
4.00	Accounts receivable	21, 503, 508	1	1	0	
5.00	Other receivable	-553, 054	1		0	
6. 00	Allowances for uncollectible notes and accounts receivable	-12, 305, 237			0	
7. 00	Inventory	880, 988		o o	Ö	
8.00	Prepaid expenses	48, 223		0	0	
9.00	Other current assets	0	) (	0	0	9. 00
10.00	Due from other funds	-41, 892, 199		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	-31, 967, 922	2	0	0	11. 00
	FIXED ASSETS					
12. 00	Land	1, 208, 757	1			
13.00	Land improvements	1, 875, 057	1	-	1	
14.00	Accumulated depreciation	-321, 773	1	0		
15.00	Buildings	52, 247, 830	1	0	0	
16.00	Accumulated depreciation	-23, 120, 904	) (	0	0	
17. 00 18. 00	Leasehold improvements Accumulated depreciation			1	0	
19. 00	Fi xed equi pment	1, 962, 144	1	1	0	
20. 00	Accumulated depreciation	-339, 510			0	
21. 00	Automobiles and trucks	23, 431	1		Ö	
22. 00	Accumulated depreciation	-23, 431	1		Ö	
23. 00	Major movable equipment	12, 922, 283	1	o o	Ö	
24. 00	Accumulated depreciation	-4, 566, 615	1	o o	Ō	
25. 00	Mi nor equi pment depreci abl e	0		0	0	
26.00	Accumulated depreciation	0		0	0	26. 00
27.00	HIT designated Assets	0	) (	0	0	27. 00
28.00	Accumulated depreciation	0	) (	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	)	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	41, 867, 269	) (	0	0	30.00
	OTHER ASSETS	1				
31. 00	Investments	318, 100			1	
32. 00	Deposits on Leases	0	1	0	1	
33. 00	Due from owners/officers	0	1	0	0	1
34. 00	Other assets	210 100	1	0	0	1
35. 00 36. 00	Total other assets (sum of lines 31-34)	318, 100 10, 217, 447	1	٦	0	1
30.00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	10, 217, 447		<u>J</u>	U	30.00
37. 00	Accounts payable	1, 145, 079	) (	0	0	37. 00
38. 00	Salaries, wages, and fees payable	694, 480	1		1	
39. 00	Payroll taxes payable	07.17.00	1	0 0	Ö	
40.00	Notes and Loans payable (short term)	0		0	0	
41.00	Deferred income	0		0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	) (	0	0	43.00
44.00	Other current liabilities	5, 801, 711		0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 641, 270	)	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0	)	٦	0	
47. 00	Notes payable	0	1	0		
48. 00	Unsecured Loans	0 700 010		0	1	
49. 00	Other long term liabilities	22, 733, 060		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	22, 733, 060	1			
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	30, 374, 330		0	0	
52.00	General fund balance	-20, 156, 883				52. 00
53. 00	Specific purpose fund			)		53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	_	56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-20, 156, 883	,	o	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	10, 217, 447			0	
55. 50	59)	10,217,447				55. 66
	(46)	I	I	I	l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provi der CCN: 15-1310 Peri od: Worksheet G-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 7/28/2020 4:40 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) 1.00 1.00 -16, 106, 353 0 2.00 -3, 002, 704 2.00 Total (sum of line 1 and line 2)
Additions (credit adjustments) (specify) 3.00 -19, 109, 057 3.00 0 4.00 4.00 0 0 0 0 0 0 REMOVE HO INTEREST EXPENSE 607, 735 0 5.00 5.00 6.00 0 6.00 0 0 0

0

0

0 9. 00

7. 00

8.00

9.00		l ol		0		l o	9.00
10.00	Total additions (sum of line 4-9)		607, 735		0		10.00
11.00	Subtotal (line 3 plus line 10)		-18, 501, 322		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	1, 655, 561		0		0	13.00
14.00		0		0		0	14.00
15. 00		0		0		0	15. 00
16.00		o		l 0		0	16. 00
17. 00		o		l o		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		1, 655, 561		0		18. 00
19. 00	Fund balance at end of period per balance		-20, 156, 883		0		19. 00
	sheet (line 11 minus line 18)		.,,				
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	REMOVE HO INTEREST EXPENSE		0				5.00
6.00			0				6.00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	o		l 0			10.00
11. 00	Subtotal (line 3 plus line 10)	o		l 0			11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15. 00			0				15. 00
16. 00			0				16, 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	_	0			18. 00
	Fund balance at end of period per balance	0		0			19. 00
	sheet (line 11 minus line 18)			]			
	1	!		1	ļ.	ļ	

7.00

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 Heal th Financial Systems
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-1310

		Т	o 12/31/2019	Date/Time Pre 7/28/2020 4:4	pared:
	Cost Center Description	Inpati ent	Outpati ent	Total	Э рііі
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	6, 071, 514		6, 071, 514	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	580		580	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	6, 072, 094		6, 072, 094	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6, 072, 094		6, 072, 094	17. 00
18. 00	Ancillary services	16, 711, 722	0	16, 711, 722	18.00
19. 00	Outpati ent servi ces	0	137, 627, 668	137, 627, 668	19.00
20.00	RHC - CASS ST	0	3, 813, 297	3, 813, 297	20.00
20. 01	RHC - N. MANCHESTER	0	2, 996, 927	2, 996, 927	20. 01
20. 02	RHC - KI SSI NGER	0	1, 550, 486	1, 550, 486	20. 02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22. 00
23.00	AMBULANCE SERVICES	0	0	0	23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26.00	HOSPI CE	0	0	0	26. 00
27.00	OTHER (SPECIFY)	0	0	0	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	22, 783, 816	145, 988, 378	168, 772, 194	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		55, 066, 650		29. 00
30.00	BAD DEBT	4, 597, 727			30.00
31.00	HOME OFFICE INTEREST EXPENSE	607, 735			31. 00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		5, 205, 462		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38. 00
39.00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		60, 272, 112		43.00
	to Wkst. G-3, line 4)				

Heal 1	h Financial Systems PARKVIEW WABASH HO	OSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
STAT	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1310	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	
			L.	7/28/2020 4: 4	O pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		168, 772, 194	1, 00
2. 00	Less contractual allowances and discounts on patients' accounts	,		111, 991, 578	
3.00	Net patient revenues (line 1 minus line 2)	11.5		56, 780, 616	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		60, 272, 112	
5. 00	Net income from service to patients (line 3 minus line 4)	,		-3, 491, 496	
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 0	Purchase di scounts			9, 753	10.00
11. 0	Rebates and refunds of expenses			0	11. 00
12. 0	Parking Lot receipts			0	12. 00
13. 0	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			256, 880	1
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other	than patients		73, 203	1
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 0				15, 202	1
	Rental of vending machines			0	21. 00
22. 0	· · ·			98, 342	•
23. 0				0	23. 00
	GAIN ON DISPOSAL OF ASSETS			1, 776	•

0 24.01

0

0 28.00

-3, 002, 704 29. 00

24. 02

24. 03

25. 00 26. 00 27. 00

7, 510

26, 126

488, 792

-3, 002, 704

24. 01

24. 02 MI SC

OTHER

24. 03 RHC INTERUNIT RENT

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems PA	RKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1310	Peri od:	Worksheet M-1	
					From 01/01/2019		
			Component	CCN: 15-8544	To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
					RHC I	772072020 4.4	O pili
		Compensation	Other Costs	Total (col	1 Reclassificati	Recl assi fi ed	
		Compensation	011101 00313	+ col . 2)	ons	Trial Balance	
				' 00 2)	0.10	(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	91, 899	0	91, 89	99 0	91, 899	1. 00
2.00	Physician Assistant	329, 135	0	329, 13	-162, 780	166, 355	2. 00
3.00	Nurse Practitioner	0	0	1	0 162, 780	162, 780	3. 00
4.00	Visiting Nurse	0	0	)	0	0	4. 00
5.00	Other Nurse	187, 351	0	187, 35	51 0	187, 351	5. 00
6.00	Clinical Psychologist	0	0		0	0	6. 00
7.00	Clinical Social Worker	0	0	)	0	0	
8.00	Laboratory Techni ci an	0	0	)	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	37, 550	0	37, 55		37, 550	
10. 00	Subtotal (sum of lines 1 through 9)	645, 935	0	645, 93	85 0	645, 935	
11. 00	Physician Services Under Agreement	0	0	1	0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	1	0	0	12.00
13.00	Other Costs Under Agreement	0	0	1	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	100 000	400.00	0	100 000	14.00
15.00	Medical Supplies	0	109, 329			109, 329	1
16.00	Transportation (Health Care Staff)	0	1, 061	1, 06	0	1, 061	
17. 00	Depreciation-Medical Equipment	U	0 401	0.46	0	0	17. 00
18. 00 19. 00	Professional Liability Insurance Other Health Care Costs	0	8, 481			8, 481 6, 854	
20. 00	Allowable GME Costs	U .	6, 854	6, 85	04	0, 854	20.00
21. 00	Subtotal (sum of lines 15 through 20)		125, 725	125, 72	25 0	125, 725	
21.00	Total Cost of Health Care Services (sum of	645, 935	125, 725			771, 660	
22.00	lines 10, 14, and 21)	040, 930	123, 723	771,00	0	//1,000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0		0 0	ő	
25. 00	Optometry	o	0	,	0 0		25. 00
25. 01	Tel eheal th	0	0	)	0 0	0	25. 01
25. 02	Chronic Care Management	0	0	)	0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	)	0 0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	201, 782	201, 78	32 0	201, 782	29. 00
30.00	Administrative Costs	307, 990	222, 728	530, 71	8 0	530, 718	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	307, 990	424, 510	732, 50	00	732, 500	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	953, 925	550, 235	1, 504, 16	0 0	1, 504, 160	32. 00
	and 31)			[			

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1310	Period: Worksheet M-1
	Component CCN: 15-8544	From 01/01/2019   To 12/31/2019   Date/Time Prepared:

			Component	CCN: 15-8544	То	12/31/2019	Date/Time Pr 7/28/2020 4:	
						RHC I	772872020 4.	40 piii
		Adjustments	Net Expenses				."	
			for Allocation	n				
			(col. 5 + col.					
			6)	_				
	FACILITY HEALTH CARE CTAFE COCTO	6. 00	7. 00					
1 00	FACILITY HEALTH CARE STAFF COSTS	ام	01 000	\				1 00
1.00	Physician Assistant	0	91, 899					1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	-	166, 355 162, 780					3. 00
4. 00	Visiting Nurse	0	162, 780	1				4. 00
4. 00 5. 00	Other Nurse	0	187, 351	1				5. 00
6. 00	Clinical Psychologist	0	107, 331					6. 00
7. 00	Clinical Social Worker	0	0					7. 00
8. 00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	37, 550					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	645, 935					10.00
11. 00	Physician Services Under Agreement	0	040, 930					11. 00
12. 00	Physician Supervision Under Agreement	0	0					12. 00
13. 00	Other Costs Under Agreement	0	0					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0					14. 00
15. 00	Medical Supplies	0	109, 329					15. 00
16. 00	Transportation (Health Care Staff)	0	1, 061	1				16. 00
17. 00	Depreciation-Medical Equipment	0	1,001	1				17. 00
18. 00	Professional Liability Insurance	0	8, 481	1				18. 00
19. 00	Other Health Care Costs	0	6, 854					19. 00
20. 00	Allowable GME Costs	o <sub>l</sub>	0, 034					20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	125, 725					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	771, 660	1				22. 00
22.00	lines 10, 14, and 21)	U	771,000	ή				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0					23. 00
24. 00	Dental	o	0	1				24. 00
25. 00	Optometry	0	0	1				25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs		_					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)		_					
	FACILITY OVERHEAD	'		•				
29. 00	Facility Costs	-22, 510	179, 272	2				29. 00
30.00	Administrative Costs	0	530, 718	3				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-22, 510	709, 990					31. 00
	30)		•					
32.00	Total facility costs (sum of lines 22, 28	-22, 510	1, 481, 650					32. 00
	and 31)							

	Financial Systems PA	IIII WADAJII I	HOSPITAL, INC.		in Lie	u of Form CMS-2	2552-10
ANALYSI	S OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (		From 01/01/2019 To 12/31/2019	Date/Time Pre	nared:
			Component	CCN. 13-0341	10 12/31/2019	7/28/2020 4: 4	
					RHC II		
		Compensation	Other Costs		Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1. 00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	318, 965	0	318, 96	5 1, 358	320, 323	1.00
2.00	Physician Assistant	84, 921	0			40, 216	2. 00
3.00	Nurse Practitioner	01,721	0		0 43, 347	43, 347	3.00
4.00	Visiting Nurse	ol	0		0 0	0	4. 00
5.00	Other Nurse	175, 170	0	175, 17	0 0	175, 170	5. 00
6.00	Clinical Psychologist	o	0		0 0	0	6.00
7.00	Clinical Social Worker	o	0		0 0	0	
8.00	Laboratory Techni ci an	13, 046	0	13, 04	6 0	13, 046	8. 00
9.00	Other Facility Health Care Staff Costs	o	0		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	592, 102	0	592, 10	2 0	592, 102	10.00
11. 00	Physician Services Under Agreement	0	0		0 0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12. 00
13. 00	Other Costs Under Agreement	0	0		0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14. 00
	Medical Supplies	0	187, 763			187, 763	
16. 00	Transportation (Health Care Staff)	0	3, 158	3, 15	8 0	3, 158	
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
	Professional Liability Insurance	0	13, 058	13, 05	8 0	13, 058	
	Other Health Care Costs	0	0		0	0	
	Allowable GME Costs		202 070	202.07	0	202 070	20.00
21. 00	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	0 502 102	203, 979			203, 979	
22. 00	lines 10, 14, and 21)	592, 102	203, 979	796, 08	0	796, 081	22. 00
ł	COSTS OTHER THAN RHC/FQHC SERVICES	l					1
23. 00	Pharmacy	ol	0		0 0	0	23. 00
24. 00	Dental	ol	0		0 0	_	24. 00
25. 00	Optometry	ol	0		o o	0	25. 00
25. 01	Tel eheal th	o	0		0 0	0	25. 01
25. 02	Chronic Care Management	o	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	o	0		0 0	0	26.00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
1	Facility Costs	0	135, 662			,	
30. 00	Administrative Costs	365, 064	93, 664			458, 728	
31. 00	Total Facility Overhead (sum of lines 29 and	365, 064	229, 326	594, 39	0	594, 390	31.00
22 00	30)	057 444	400 005	1 200 47	1	1 200 474	22 00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	957, 166	433, 305	1, 390, 47		1, 390, 471	32. 00
ı	unu 01)	ı		I	I	ı	I

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1310	Peri od:	Worksheet M-1
		From 01/01/2019	
	Component CCN, 1E 0E41	To 10/21/2010	Data/Tima Dranarad

			Component C	CCN: 15-8541	То	12/31/2019	Date/Time F 7/28/2020 4	
						RHC II	772072020 2	4. 40 piii
		Adjustments	Net Expenses				.1	
			or Allocation					
		(	[col. 5 + col.					
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1. 00	Physi ci an	0	320, 323					1.00
2.00	Physician Assistant	0	40, 216					2. 00
3.00	Nurse Practitioner	0	43, 347					3.00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	175, 170					5. 00
6.00	Clinical Psychologist	0	0					6. 00
7.00	Clinical Social Worker	0	12.044					7. 00
8. 00 9. 00	Laboratory Technician	0	13, 046					8. 00
10. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	0	592, 102					9.00
	Physician Services Under Agreement	0	592, 102					11.00
	Physician Supervision Under Agreement	0	0					12.00
	Other Costs Under Agreement	0	0					13. 00
	Subtotal (sum of lines 11 through 13)		0					14. 00
15. 00	Medical Supplies	0	187, 763					15. 00
	Transportation (Health Care Staff)	0	3, 158					16.00
	Depreciation-Medical Equipment	0	3, 130					17. 00
	Professional Liability Insurance	0	13, 058					18. 00
	Other Health Care Costs	Ö	10,000					19.00
	Allowable GME Costs	J.	Ĭ					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	203, 979					21.00
22. 00	Total Cost of Health Care Services (sum of	0	796, 081					22. 00
22.00	lines 10, 14, and 21)	٦	, , 0, 00 .					1 22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0					23. 00
24.00	Dental	0	o					24. 00
25.00	Optometry	0	o					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD							
	Facility Costs	-28, 910	106, 752					29. 00
30. 00	Administrative Costs	784	459, 512					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-28, 126	566, 264					31. 00
22.02	30)	20.424	1 2/2 2/5					22.00
32. 00	Total facility costs (sum of lines 22, 28	-28, 126	1, 362, 345					32. 00
	and 31)		I					ı

Heal th	Financial Systems PA	ARKVIEW WABASH I	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1310	Peri od:	Worksheet M-1	
			Component (	CCN: 15-8542	From 01/01/2019 To 12/31/2019		
-					RHC III	7/28/2020 4:4	U piii
		Compensation	Other Costs	Total (col	1 Reclassificati	Recl assi fi ed	
		Compensation	011101 00313	+ col . 2)	ons	Trial Balance	
				1 (01. 2)	0113	(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	4, 736	0	4, 73	6 0	4, 736	1.00
2.00	Physician Assistant	133, 089	0			133, 089	2. 00
3. 00	Nurse Practitioner	50, 138	0			50, 138	3. 00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5. 00	Other Nurse	54, 766	0	54, 76	6 0	54, 766	5. 00
6. 00	Clinical Psychologist	0	0		0 0	0	6.00
7. 00	Clinical Social Worker	o	0		0 0	0	7. 00
8. 00	Laboratory Techni ci an	o	0		0 0	0	8.00
9. 00	Other Facility Health Care Staff Costs	o	0		0 0	0	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	242, 729	0	242, 72	9 0	242, 729	10.00
11. 00	Physician Services Under Agreement	0	0	,	0 0	0	11. 00
12. 00	Physician Supervision Under Agreement	o	0		0 0	Ō	12.00
13. 00	Other Costs Under Agreement	o	0		0 0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	o	0		0 0	0	14. 00
15. 00	Medical Supplies	o	60, 595	60, 59	5 0	60, 595	•
16. 00	Transportation (Health Care Staff)	o	3, 436			3, 436	16. 00
17. 00	Depreciation-Medical Equipment	o	3, 752			3, 752	17. 00
18. 00	Professional Liability Insurance	o	6, 518	1		6, 518	18. 00
19. 00	Other Health Care Costs	o	671	67		671	19. 00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	74, 972	74, 97	2 0	74, 972	21. 00
22. 00	Total Cost of Health Care Services (sum of	242, 729	74, 972			317, 701	22. 00
	lines 10, 14, and 21)		•				
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24. 00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	82, 543			82, 543	29. 00
30. 00	Administrative Costs	116, 236	91, 170			2077 100	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	116, 236	173, 713	289, 94	.9	289, 949	31. 00
22.00	30)	250 275	240 (25	(07.45		/07 /50	22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	358, 965	248, 685	607, 65	0	607, 650	32. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1310	Peri od: Worksheet M-1
	Component CCN: 15-8542	To 12/31/2019 Date/Time Prepared:

							7/28/2020 4	: 40 pm
					RHC I	11		
		Adjustments	Ne	t Expenses				
			for	Allocation				
			(co	I. 5 + col.				
			`	6)				
		6, 00		7. 00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	_	7.00				
1.00	Physi ci an	0	1	4, 736				1.00
2. 00	Physician Assistant	0	()	133, 089				2.00
3. 00	Nurse Practitioner	0	(	50, 138				3.00
		0	(	30, 136				
4.00	Visiting Nurse	0	1					4.00
5.00	Other Nurse	0	7	54, 766				5. 00
6. 00	Clinical Psychologist	0	9	0				6. 00
7.00	Clinical Social Worker	0		0				7. 00
8.00	Laboratory Techni ci an	0		0				8. 00
9.00	Other Facility Health Care Staff Costs	0		0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0		242, 729				10.00
11.00	Physician Services Under Agreement	0		0				11. 00
12.00	Physician Supervision Under Agreement	0	ol .	0				12. 00
13. 00	Other Costs Under Agreement	0		0				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0		0				14. 00
15. 00	Medical Supplies	0	()	60, 595				15. 00
16. 00	Transportation (Health Care Staff)	0	(	3, 436				16.00
		0	(					
17. 00	Depreciation-Medical Equipment	0	1	3, 752				17. 00
18. 00	Professional Liability Insurance	0	2	6, 518				18. 00
19. 00	Other Health Care Costs	0	7	671				19. 00
20. 00	Allowable GME Costs							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0		74, 972				21. 00
22.00	Total Cost of Health Care Services (sum of	0		317, 701				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0		0				23. 00
24.00	Dental	0		0				24. 00
25.00	Optometry	0	ol	0				25. 00
25. 01	Tel eheal th	0	ol .	0				25. 01
25. 02	Chronic Care Management	0		0				25. 02
26. 00	All other nonreimbursable costs	0		0				26. 00
27. 00	Nonallowable GME costs	O	1	O				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0				28.00
26.00		U	Ί	U				20.00
	through 27)		<u> </u>					
20.00	FACILITY OVERHEAD	^	J	00.540				
29. 00	Facility Costs	0	1	82, 543				29. 00
30. 00	Administrative Costs	-30		207, 376				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-30	9	289, 919				31. 00
	30)							
32.00	Total facility costs (sum of lines 22, 28	-30	)	607, 620				32. 00
	and 31)							

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2019 To 12/31/2019		
					RHC I		
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 32	'				1. 00
2.00	Physician Assistant	0.00	l .				2. 00
3.00	Nurse Practitioner	3. 21	10, 882				3. 00
4.00	Subtotal (sum of lines 1 through 3)	3. 53			8, 085		
5.00	Visiting Nurse	0.00	l e			0	
6.00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0. 00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3. 53	12, 220			12, 220	8. 00
9.00	Physician Services Under Agreements		0			0	9. 00
7. 00	Triysi et all sel vi ces under Agreements	1	· · · · · ·				7. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
	Total costs of health care services (from Wk					771, 660	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (si	um of lines 10	and 11)			771, 660	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. N	1-1, col. 7, li	ne 31)		709, 990	14. 00
15.00							
16.00							16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					1, 296, 276	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		1, 296, 276	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		2, 067, 936	20. 00

Hoal th	Financial Systems P.	ARKVIEW WABASH	HUSDI TVI	LNC		In Lie	eu of Form CMS-2	2552_10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S				CN: 15-1310	Peri od:	Worksheet M-2	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	THE STATE OF THE S	2				From 01/01/2019		
			Compor	nent (	CCN: 15-8541	To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
						RHC II	1/28/2020 4:4	о рііі
		Number of FTE	Total Vi	sits	Producti vi tv	Minimum Visits	Greater of	
		Personnel			Standard (1)			
					. ,	3)	4	
		1.00	2. 00		3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons	1					T	
1.00	Physi ci an	1. 22		4, 337		· ·		1. 00
2.00	Physician Assistant	0. 37		1, 045				2.00
3.00	Nurse Practitioner	0. 62		1, 783		· ·		3. 00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	2. 21 0. 00		7, 165 0		7, 203	7, 203 0	4. 00 5. 00
6. 00	Visiting Nurse Clinical Psychologist	0.00		0				6.00
7. 00	Clinical Social Worker	0.00		0			0	7. 00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00		0				7. 01
7. 02	Di abetes Self Management Training (FQHC	0.00		0			0	7. 02
7.02	only)	0.00		J				7.02
8.00	Total FTEs and Visits (sum of lines 4	2. 21		7, 165			7, 203	8. 00
	through 7)							
9. 00	Physician Services Under Agreements			0			0	9. 00
							1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HUGDITAL DAGE	D DUC/EOU	C SED	VICES		1.00	
10. 00	Total costs of health care services (from Wk				VICES		796, 081	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,			,			770,001	
12. 00	Cost of all services (excluding overhead) (s						796, 081	
13. 00	Ratio of hospital -based RHC/FQHC services (I			2)			1.000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr				ne 31)		566, 264	
15. 00	Parent provider overhead allocated to facili				•		539, 077	
4/ 00	00 T + + + + + + + + + + + + + + + + + +							1 4 / 00

1, 105, 341

1, 105, 341 1, 105, 341 19. 00

1, 901, 422 20. 00

16.00 17. 00

18. 00

16.00 Total overhead (sum of lines 14 and 15)
17.00 Allowable GME overhead (see instructions)

18.00 Enter the amount from line 16
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Li∈	eu of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2019 To 12/31/2019	Date/Time Prep 7/28/2020 4:40	
					RHC III		
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 71		·	·		1. 00
2.00	Physician Assistant	0. 00	l .	_,			2. 00
3. 00	Nurse Practitioner	0. 55					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 26			4, 137		4. 00
5.00	Visiting Nurse	0.00	l e			0	
6.00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0.00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	O			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1. 26	3, 310			4, 137	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
7. 00	Triysi ci air sei vi ces under Agreements		· · · · · ·		_	0	7. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
	Total costs of health care services (from Wks					317, 701	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (si	um of lines 10	and 11)			317, 701	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. M	1-1, col. 7, li	ne 31)		289, 919	14. 00
15.00							
16.00	Total overhead (sum of lines 14 and 15)	- '	•			530, 353	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					530, 353	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		530, 353	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		848, 054	20. 00

Heal th	Financial Systems PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1310	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8544	From 01/01/2019 To 12/31/2019	Date/Time Prep 7/28/2020 4:40	
		Title XVIII	RHC I	7,20,2020 11 1	
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. Line 20)		2, 067, 936	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li			122, 294	•
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 945, 642	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12, 220	•
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		12, 220	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			12, 220 159. 22	6. 00 7. 00
7.00	Augusted Cost per visit (Title 3 divided by Title 0)		Cal cul ati on		7.00
			Prior to Jan.	On or After	
			1 (Rate Period		
			1)	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9.00	Rate for Program covered visits (see instructions)		159. 22	159. 22	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		1, 781	0	ł
11.00	Program cost excluding costs for mental health services (line		283, 571	0	•
12. 00 13. 00	Program covered visits for mental health services (from contr. Program covered cost from mental health services (line 9 x li	*	0	0	12. 00 13. 00
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	283, 571	16. 00
16. 01	Total program charges (see instructions)(from contractor's re	•		262, 904	1
16. 02	Total program preventive charges (see instructions)(from prov	-		1, 360	•
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			1, 467 220, 331	16. 03 16. 04
10.01	(Titles V and XIX see instructions.)	o and roy trines . coy		220,001	10.01
16. 05	Total program cost (see instructions)		0	221, 798	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		6, 690	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		50, 971	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			221, 798	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		37, 933	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)			259, 731	•
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	•
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24. 00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)		0	25. 00 25. 50
	Demonstration payment adjustment amount before sequestration	3)		0	
	Net reimbursable amount (see instructions)			259, 731	
26. 01	Sequestration adjustment (see instructions)			5, 195	•
26. 02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			371, 949	
28. 00 29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.01)	02 27 and 201		0 -117, 413	
	Protested amounts (nonallowable cost report items) in accorda			-117, 413	
_0.00	chapter I, §115.2			J	30. 30

Heal th	Financial Systems PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1310	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8541	From 01/01/2019 To 12/31/2019	Date/Time Pre 7/28/2020 4:4	
		Title XVIII	RHC II		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. Line 20)		1, 901, 422	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li			178, 553	1
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 722, 869	3. 00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7, 203	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		7 202	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			7, 203 239. 19	
7.00	Augusted cost per visit (fille 3 divided by fille 0)		Cal cul ati on		7.00
			D : 1	0 461	
			Prior to Jan.	On or After Jan. 1 (Rate	
			1)	Peri od 2)	
			1.00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	
9.00	Rate for Program covered visits (see instructions)		239. 19	239. 19	9. 00
10.00	CALCULATION OF SETTLEMENT		1 (27	0	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	*	1, 637 391, 554	0	1
12. 00	Program covered visits for mental health services (from contra	*	391, 334	0	12.00
13. 00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	391, 554	
16. 01	Total program charges (see instructions) (from contractor's re	•		398, 537	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	-		123, 366 121, 204	
16. 04	Total Program non-preventive costs ((Tine 16.02/Tine 16.07) times	•		212, 634	
	(Titles V and XIX see instructions.)			,	
16. 05	Total program cost (see instructions)		0	333, 838	
17. 00	Primary payer amounts	(6		0	
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		4, 558	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		54, 123	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			333, 838	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		39, 772	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			373, 610	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)	rusti spa)		0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
25. 50	, , , , , ,	s)		0	
	Demonstration payment adjustment amount before sequestration				25. 99
26. 00	Net reimbursable amount (see instructions)			373, 610	26. 00
26. 01	Sequestration adjustment (see instructions)				26. 01
26. 02	, , , , , , , , , , , , , , , , , , , ,				26. 02
27. 00	Interim payments Tentative settlement (for contractor use only)			309, 867	27.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)			29.00
	Protested amounts (nonallowable cost report items) in accorda				30.00
	chapter I, §115.2	•			1

Heal th	Financial Systems PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1310	Peri od:	Worksheet M-3	
SERVI (	ES	Component CCN: 15-8542	From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title XVIII	RHC III	7/28/2020 4: 40	о рііі
				1. 00	
1 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES	W+ M 2 1: 20)		0.40, 05.4	1 00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Cost of vaccines and their administration (from Wkst. M-4, li			848, 054 95, 509	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		752, 545	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 137	1
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			4, 137	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0-11	181. 91	7. 00
			Cal cul ati on	OF LIMIT (I)	
			Prior to Jan.	On or After	
			, ,	Jan. 1 (Rate	
			1)	Peri od 2)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00	8.00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	181. 91	181. 91	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	1, 006	0	10. 00
11. 00	Program cost excluding costs for mental health services (line	•	183, 001	0	
12.00	Program covered visits for mental health services (from contra	•	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x lill Limit adjustment for mental health services (see instructions	*	0	0	
15. 00	Graduate Medical Education Pass Through Cost (see instructions			O	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	183, 001	
16. 01	Total program charges (see instructions)(from contractor's re-	cords)		214, 100	16. 01
16. 02	Total program preventive charges (see instructions)(from prov	•		50, 718	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		43, 351	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		109, 064	16. 04
16. 05	Total program cost (see instructions)		0	152, 415	16. 05
17. 00	Pri mary payer amounts			0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		3, 320	18. 00
10 00	records)	ns) (from contractor		22 012	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (Irom contractor		32, 012	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			152, 415	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		38, 573	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			190, 988	
23. 00	Allowable bad debts (see instructions)			0	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 40 (1 0113)		0	
25. 50		s)		0	25. 50
	Demonstration payment adjustment amount before sequestration				25. 99
26. 00	1			190, 988	
26. 01	Sequestration adjustment (see instructions)				26. 01
26. 02 27. 00	, , , , , , , , , , , , , , , , , , , ,			134, 144	26. 02
	Tentative settlement (for contractor use only)			134, 144	1
		02 27 and 20)		-	29. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 21, and 20)		33, 024	27.00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1310	Peri od:	Worksheet M-4
VACCINE COST			From 01/01/2019	
		Component CCN: 15-8544	To 12/31/2019	Date/Time Prepared:
				7/28/2020 4:40 pm
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		Title XVIII	RHC I		
			Pneumococcal	l nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		645, 935	645, 935	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	I health care staff time	0.000520	0. 003302	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	e 1 x line 2)	336	2, 133	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from	om your records)	16, 640	26, 526	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	16, 976	28, 659	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshee	et M-1, col. 7, line 22)	771, 660	771, 660	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 296, 276	1, 296, 276	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total	al direct cost (line 5	0. 021999	0. 037139	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ine 8)	28, 517	48, 142	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a	administration (sum of	45, 493	76, 801	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	136	863	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10,	/line 11)	334. 51	88. 99	12.00
13.00	Number of pneumococcal and influenza vaccine injections adminis	stered to Program	57	212	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (the	eir) administration	19, 067	18, 866	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei			122, 294	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	line 2)			
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	ts (their)		37, 933	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this a	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1310	Peri od:	Worksheet M-4
VACCINE COST			From 01/01/2019	
		Component CCN: 15-8541	To 12/31/2019	Date/Time Prepared:
				7/28/2020 4:40 pm
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		Title XVIII	RHC II		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		592, 102	592, 102	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	I health care staff time	0. 001533	0. 005204	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	e 1 x line 2)	908	3, 081	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from	om your records)	39, 332	31, 435	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	40, 240	34, 516	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshee	et M-1, col. 7, line 22)	796, 081	796, 081	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 105, 341	1, 105, 341	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total	al direct cost (line 5	0. 050548	0. 043357	8. 00
	divided by line 6)				l
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ine 8)	55, 873	47, 924	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) a lines 5 and 9)	administration (sum of	96, 113	82, 440	10. 00
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	292	991	11. 00
	Cost per pneumococcal and influenza vaccine injection (line 10,		329. 15	83. 19	12.00
13. 00	Number of pneumococcal and influenza vaccine injections adminis		67	213	
	benefi ci ari es				1
14.00	Program cost of pneumococcal and influenza vaccine and its (the	eir) administration	22, 053	17, 719	14. 00
	(line 12 x line 13)				l
15. 00	Total cost of pneumococcal and influenza vaccine and its (their			178, 553	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				l
16. 00	Total Program cost of pneumococcal and influenza vaccine and i			39, 772	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this a	amount to Wkst. M-3,			
	line 21)				l .

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1310	Peri od:	Worksheet M-4
VACCINE COST			From 01/01/2019	
		Component CCN: 15-8542	To 12/31/2019	Date/Time Prepared:
				7/28/2020 4:40 pm
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		Title XVIII	RHC III		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		242, 729	242, 729	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	0. 001334	0. 006774	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	324	1, 644	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	13, 201	20, 611	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	13, 525	22, 255	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	et M-1, col. 7, line 22)	317, 701	317, 701	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		530, 353	530, 353	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	al direct cost (line 5	0. 042571	0. 070050	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	22, 578	37, 151	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	36, 103	59, 406	10. 00
	lines 5 and 9)	(6	404	500	
11. 00	Total number of pneumococcal and influenza vaccine injections		104	528	
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10	-	347. 14	112. 51	
13. 00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	45	204	13. 00
14. 00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	15, 621	22, 952	14. 00
15. 00	Total cost of pneumococcal and influenza vaccine and its (theil of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			95, 509	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		38, 573	16. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/F SERVICES RENDERED TO PROGRAM BENEFICIARIES	OHC PROVIDER FOR	Provider CCN: 15-1310 Component CCN: 15-8544	Peri od: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 7/28/2020 4:40 pm

	compenent cont. 10 con 1	10 12/01/201/	7/28/2020 4: 40	
		RHC I		
		Pai	rt B	
		mm/dd/yyyy	Amount	
		1, 00	2.00	
O Total interim payments paid to hospital-based RHC/FQHC			371, 949	1
O Interim payments payable on individual bills, either submitte	ed or to be submitted to		0,1,717	2
the contractor for services rendered in the cost reporting pe				~
"NONE" or enter a zero	errod. It holle, write			
O List separately each retroactive lump sum adjustment amount I	based on subsequent			3
revision of the interim rate for the cost reporting period.				د ا
payment. If none, write "NONE" or enter a zero. (1)	Also show date of each			
Program to Provider				
				١.
1			0	
2			0	3
3			0	3
4			0	3
5			0	] 3
Provider to Program				
0			0	3
1			0	3
2			0	3
3			0	3
4			0	3
9   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	8)		o	1 3
O Total interim payments (sum of lines 1, 2, and 3.99) (transfer			371, 949	4
27)				
TO BE COMPLETED BY CONTRACTOR				ĺ
O List separately each tentative settlement payment after desk	review. Also show date of	-		1 5
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider			•	İ
1			0	1 5
2			0	5
3			0	
Provider to Program				
0			0	1 5
1				5
2				5
9   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	0)			5
			ا	
	cost report. (1)			1
1 SETTLEMENT TO PROPERTY			0	1
2 SETTLEMENT TO PROGRAM			117, 413	1
O Total Medicare program liability (see instructions)			254, 536	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	8
O Name of Contractor				

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1310 Component CCN: 15-8541	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Prepared:
				7/28/2020 4:40 pm

	demperierre donc le de l'	0 12/01/201/	7/28/2020 4: 40	
		RHC II		
		Par	rt B	
		mm/dd/yyyy	Amount	
		1. 00	2. 00	
O Total interim payments paid to hospital-based RHC/FQHC			309, 867	1
Ulnterim payments payable on individual bills, either submit	tted or to be submitted to		0	2
the contractor for services rendered in the cost reporting			Ĭ	^
"NONE" or enter a zero	perred. IT hone, write			
U List separately each retroactive lump sum adjustment amount	t hased on subsequent			3
revision of the interim rate for the cost reporting period.				`
payment. If none, write "NONE" or enter a zero. (1)	711 30 311011 date of eden			
Program to Provider				1
11			0	1 3
2				
3			0	
4				3
5 Daniel dans to Danielan			0	١ ،
Provider to Program				١,
0			0	
1			0	
2			0	
3			0	
4	>		0	3
9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		309, 867	4
27)				
TO BE COMPLETED BY CONTRACTOR				١.
List separately each tentative settlement payment after des	sk review. Also show date of			5
each payment. If none, write "NONE" or enter a zero. (1)				-
Program to Provider				١.
1			0	
2			0	
3			0	. 5
Provider to Program		1		
0			0	
1			0	5
2			0	
9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
Determined net settlement amount (balance due) based on the	e cost report. (1)			1
1 SETTLEMENT TO PROVIDER			56, 271	6
2 SETTLEMENT TO PROGRAM			0	6
O Total Medicare program liability (see instructions)			366, 138	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1. 00	2. 00	
				8

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1310	Peri od: From 01/01/2019	
		Component CCN: 15-8542	To 12/31/2019	Date/Time Prepared: 7/28/2020 4:40 pm

		'		7/28/2020 4: 40	O pm
			RHC III		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	Total interim payments paid to hospital-based RHC/FQHC			134, 144	1. (
	Interim payments payable on individual bills, either submit			0	2. (
	the contractor for services rendered in the cost reporting $\mu$	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	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				0	
02					3.
03				0	
04				0	3.
. 05	Provider to Program			0	3.
50	Provider to Program			0	3.
51					
52					3.
53					3.
54					3.
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		0	3.
	Total interim payments (sum of lines 1, 2, and 3.99) (transf			134, 144	4.
	27)			,	
ī	TO BE COMPLETED BY CONTRACTOR		•		ĺ
	List separately each tentative settlement payment after desk	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
F	Program to Provider		-		
01				0	
02				0	
03				0	5.
	Provider to Program				۱ ـ
50				0	
51 52					5. 5.
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	00)			5. 5.
	Determined net settlement amount (balance due) based on the			١	6.
	SETTLEMENT TO PROVIDER	cost report. (1)		53, 024	6.
	SETTLEMENT TO PROGRAM			03,024	6.
	Total Medicare program liability (see instructions)			187, 168	
30	Total modification program readility (300 motivations)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
. 00	Name of Contractor				