PARKVIEW LAGRANGE HOSPITAL

In Lieu of Form CMS-2552-10

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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1323 Peri od. Worksheet S From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY Date/Time Prepared: То 12/31/2022 5/26/2023 4:02 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2023 Time: 4:02 pm use only 2. []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, "L" for low, or "N" for no. 3 0 Ē 4 [6. Date Received: 7. Contractor No. Contractor 5.]Cost Report Status 10. NPR Date: Γ 11. Contractor's Vendor Code: (1) As Submitted use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) 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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW LAGRANGE HOSPITAL (15-1323) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 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. SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR ELECTRONI C CHECKBOX 2 SIGNATURE STATEMENT 1 have read and agree with the above certification 1 statement. I certify that I intend my electronic Jeanne Wickens γ signature on this certification be the legally

			binding equivalent of my original signature.	
2	Signatory Printed Name	Jeanne Wickens		2
3	Signatory Title	CF0/SVP		3
4	Date	(Dated when report is electronica		4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	187, 465	-190, 791	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	29, 850	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	217, 315	-190, 791	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

						To 12/31/		Date/Ti 5/26/20		
	1.00	2.00		3.00			4.00			
	Hospital and Hospital Health Care Co									
00	Street: 207 NORTH TOWNLINE ROAD	PO Box:								1.0
00	City: LAGRANGE	State: IN				ity: LAGRANGE			(5	2.0
		Component Name	CCN	CBSA				nt Syste		
			Number	Numbe	er Type	Certi fi ed	-	0, or		4
		1.00	0.00	0.00	1.00		V	XVIII	XIX	-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	-
~~	Hospital and Hospital-Based Componer		454000	0001	- 4	05 (01 (0005	N			-
00	Hospi tal	PARKVIEW LAGRANGE	151323	9991	5 1	05/01/2005	N	0	P	3.0
00		HOSPI TAL					1			1 4 6
00	Subprovider - IPF						1			4.0
00	Subprovider - IRF						1			5.0
00	Subprovider - (Other)		157000		_	05 (04 (0005				6.0
00	Swing Beds - SNF	PARKVIEW LAGRANGE	15Z323	9991	5	05/01/2005	N	0	N	7.0
~~		HOSPITAL - SWING					1			
00	Swing Beds - NF						1			8.0
00	Hospital-Based SNF						1			9.0
	Hospital -Based NF						ł			10.0
. 00	Hospital -Based OLTC						ł			11.0
	Hospital-Based HHA						ł			12.0
	Separately Certified ASC						ł			13.0
	Hospital -Based Hospice						ł			14.
. 00	Hospital -Based Health Clinic - RHC						ł			15.
	Hospital-Based Health Clinic - FQHC						1			16.
. 00	Hospital-Based (CMHC) I						1			17.
	Renal Dialysis						1			18.
. 00	Other					From:	<u> </u>	To:		19.
						1.00		2.0		-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
	Type of Control (see instructions)					2	522	12/ 51/	2022	20.
. 00	Type of control (see thist detroits)					2				21.
				-	1.00	2.00		3.0	00	1
	Inpatient PPS Information									
. 00	Does this facility qualify and is it	currently receiving pa	avments fo	r 🗌	N	N				22.0
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no. Is	sthis							
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
	Did this hospital receive interim UC	Ps, including supplement	ntal UCPs,	for	N	N				22.
	this cost reporting period? Enter in									
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or			he						
	cost reporting period occurring on o	r after October 1. (see	9							
	instructions)									
. 02	Is this a newly merged hospital that				N	N				22.
	determined at cost report settlement			Iumn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			no,						
00	for the portion of the cost reportin				N I					0.00
. 03	Did this hospital receive a geograph				Ν	N		N		22.
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			er						
		•								
	reporting period occurring on or aft Does this hospital contain at least									
	counted in accordance with 42 CFR 41									
	yes or "N" for no.	2 Enter in corum	,							
04	Did this hospital receive a geograph	ic reclassification fro	om urhan +	o						22.
0 7	rural as a result of the revised OMB									22.
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	3								
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41									
	yes or "N" for no.		, ,							
				e		2 N				23.
. 00	Which method is used to determine Me	aicaid days on lines 24	∔ and∕or 2	5 I		Z IN				ZJ.
. 00	Which method is used to determine Me below? In column 1, enter 1 if date	3				2 11				25.
00		of admission, 2 if cens	sus days,	or 3		2 11				23.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	LAGRANGE	Provider CC	CN: 15-1323	Peri od:	In Lieu	Worksh		
				From 01/0 To 12/3		Part I Date/T 5/26/2	ime Pre 023 4:0	epared 02 pm
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO daj	ys Med	ther di cai d days	
	1.00	2.00	3.00	4.00	5.00		5.00	
 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. OI If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid 	0			0		0	C	24.1
HMO paid and eligible but unpaid days in column 5.				Urban/R	Jural S		- Coogr	
				1. (2.		-
5.00 Enter your standard geographic classification (not wa		s at the be	ginning of	the	2			26.0
 cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 	age) status ~ "2" for i	rural. If a	d of the co pplicable,	st	2			27.0
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status i	n	0			35.0
				Begi ni	ni ng:	Endi	ng:	
			0/ 6	1. (00	2.	00	
5.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		script line	36 TOP NUM	ber				36.
7.00 If this is a Medicare dependent hospital (MDH), enter		er of perio	ds MDH stat	us	О			37.
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for								37.
instructions) 3.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
				Y/		Y/ 2.		-
Description of the statistical statement of the statem), (İi), on the mileage i)? Enter	r (iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	ume N mn es		<u> </u>		39.
0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	er "Y" for				N		40.
					V 1.00	2.00	XIX 3.00	-
Prospective Payment System (PPS)-Capital						1		
 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Do Is this facility eligible for additional payment excellent 	eption for	extraordi n	ary circums	tances	e N N	N N	N N	45.
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c				-	N	N	N	47.
8.00 Is the facility electing full federal capital payment Teaching Hospitals		4			N	N	N	48.
 b. 00 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2. cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this cost report. 	"Y" for yes 27, 2020, olumn 1 is ams in the CRs) MA din er 27, 2020 residents n column 1. cost report	s or "N" fo under 42 "Y", or if prior year ect GME pa D, if line in approve If column ting period	r no in col CFR 413.78(this hospi or penulti yment reduc 56, column d GME progr 1 is "Y", ? Enter "Y	umn 1. For b)(2), see tal was mate year, tion? Enter 1, is yes, ams trained did " for yes c	N			56.
"N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFR which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple	applicable { 413.77(e on duty, i	e. For cost)(1)(iv) a f the resp	reporting nd (v), reg onse to lin	periods ardless of e 56 is "Y"				

ISPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1323	Peri od:		Worksheet S-2	
					From 01/01/ To 12/31/	2022	Part I Date/Time Pre <u>5/26/2023 4:0</u>	
					-	V 1.00	XVIII XIX 2.00 3.00	-
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	compl e	te Wkst. D-5.		s as	Ν	2.00 0.00	58.
. 00	Are costs claimed on line 100 of Worksheet A? If yes	, comp	lete Wkst. D-2	2, Pt. I. NAHE 413.85	5 Workshee	t A	Pass-Through	59.
				Y/N	Line #		Qual i fi cati on Cri teri on Code	
				1.00	2.00		3.00	1
00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (umn 1. R) NAH	see If column 1 E MA payment	N				60.
		Y/N	IME	Direct GME	IME		Direct GME	
		1.00	2.00	3.00	4.00		5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care	N				0.00	0.00	61.
01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							01.
02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61
03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see							61
04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).							61.
05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.
06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61
		Pro	ogram Name	Program Cod	le Unweight IME FTE C		Unweighted Direct GME FTE Count	
10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	0.00	4.00	41
10	special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	
20	Of the FTĚs 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, the direct GME FTE unweighted count.					0.00	0. 00	61.
	,						4.00	-
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	ר (HRSA)			1.00	
00	Enter the number of FTE residents that your hospital	trai ne	d in this cost		eriod for wh	i ch	0.00	62.
01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teach ram. (ing Health Cer see instructio		to your hosp	i tal	0. 00	62.
	Teaching Hospitals that Claim Residents in Nonprovide							

USPI I	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Provider C		eriod:	Worksheet S-2	2
				To	rom 01/01/2022 0 12/31/2022	Part I Date/Time Pre 5/26/2023 4:0	
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovi der	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea	r FTE Residents in N	lonprovider Settinas				
	period that begins on or after J	uly 1, 2009 and befo	ore June 30, 2010.				
4.00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		5	, j	FTËs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1.00	2.00	Si te	4.00	F 00	-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 (
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Voar ETE Docidante :	n Nonnrovidor Cottin	1.00	2.00	3.00	
	beginning on or after July 1, 20		n Nonprovider Setting	JSEffective i	or cost report	ing periods	
5. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
		Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				Site	nospi tai	COI. 4))	
		1.00	2.00	3.00	4.00	5.00	1
7.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0. 00	0. 000000	0 67.0

Health Financial Systems PARKVIEW LAGRANGE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provider CC	·N· 15_1323	In Period:		Form CMS-	
HOST THE AND HOST THE HEALTH GALL COMPLEX TREATH OAT ON DATA			From 01/01/2 To 12/31/2	022 Par 022 Dat	t I 26/2023 4:	epared:
					1.00	
68.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 MAC to apply the new DGME formula in accordance with the FY 20 (August 10, 2022)?	2, did you o	btain permiss	ion from you		N	68.00
Inpetient Devekieteie Facility DDC				1.00 2	. 00 3. 00	
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or o	loes it conta	ain an IPF su	bprovi der?	N		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 recent cost report filed on or before November 15, 2004? Enter 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility trais program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began (see instructions) Inpatient Rehabilitation Facility PPS	er "Y" for y n residents er "Y" for y	es or "N" for in a new tea es or "N" for	no. (see chi ng no.		0	71.00
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), o	or does it c	ontain an IRF		N		75.00
 subprovider? Enter "Y" for yes and "N" for no. 76.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting to the second secon	2004? Enter ning program Column 3: If	"Y" for yes in accordanc column 2 is	or "N" for e with 42 Y,		0	76.00
					1.00	-
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a	and "N" for	no			N	80.00
81. 00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEFRA Providers			g period? En	iter	N	81.00
 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 1 86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 				no.	Ν	85.00 86.00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	cl assi fi ed	under sectior			Ν	87.00
			Approved f Permanen Adjustmer (Y/N)	nt P	umber of Approved ermanent justments 2.00	
88.00 Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions)						0 88.00
Column 2: Enter the number of approved permanent adjustments.		Wkst. A Line	e Effectiv	e /	Approved	
		No.	Date	Ac Ar	ermanent djustment nount Per ischarge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A lir	ne number	1.00	2.00		3.00	89.00
on which the per discharge permanent adjustment approval was b Column 2: Enter the effective date (i.e., the cost reporting p beginning date) for the permanent adjustment to the TEFRA targ per discharge. Column 3: Enter the amount of the approved permanent adjustment	based. beriod get amount					
TEFRA target amount per discharge.						
			V 1.00		XI X 2.00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N		Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the	e cost repor	t either in	N		N	91.00
full or in part? Enter "Y" for yes or "N" for no in the applic 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cat				N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicabl 93.00 Does this facility operate an ICF/IID facility for purposes of		d XIX? Enter	N		Ν	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, ar	nd "N" for ne	o in the	N		Ν	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of			0. 00 N		0. 00 N	95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appli	cable colum	n.	0.00		0.00	97.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		NGE HOSPITAL Provider C	CN: 15-1323	Peri od		u of Form CMS- Worksheet S-2	
	5,			From C	1/01/2022 2/31/2022	Part I Date/Time Pre	
					V	5/26/2023 4: (XI X	02 pm
					v 1.00	2.00	-
8.00 Does title V or XIX follow Medicare (title XVIII) stepdown adjustments on Wkst. B, Pt. I, col. 25? E	nter "Y"				N	N	98.0
column 1 for title V, and in column 2 for title XI 8.01 Does title V or XIX follow Medicare (title XVIII) C, Pt. 1? Enter "Y" for yes or "N" for no in colum	for the r				Y	Y	98.0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y"					Y	Y	98.0
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) reimbursed 101% of inpatient services cost? Enter					Ν	Ν	98.0
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) outpatient services cost? Enter "Y" for yes or "N"	nd	N	Ν	98.0			
<pre>in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" f column 2 for title XIX</pre>					N	Y	98.0
8.06 Does title V or XIX follow Medicare (title XVIII) Pts. I through IV? Enter "Y" for yes or "N" for no column 2 for title XIX.					Υ	Y	98.0
Rural Providers 05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it electe	ed the all	-inclusive met	hod of payme	ent	Y N		105. 0 106. 0
for outpatient services? (see instructions) 07.00Column 1: If line 105 is Y, is this facility eligi training programs? Enter "Y" for yes or "N" for no Column 2: If column 1 is Y and line 70 or line 75	o in colum 5 is Y, do	n 1. (see ins you train I&F	structions) Rs in an		Ν		107.0
approved medical education program in the CAH's ex Enter "Y" for yes or "N" for no in column 2. (see 08.00 Is this a rural hospital qualifying for an excepti CFR Section §412.113(c). Enter "Y" for yes or "N"	e instruct on to the	i ons)	.,	12	N		108. (
ork section 3412. (15(c). Litter 1 for yes of h	101 110.	Physi cal	Occupation	al	Speech	Respi ratory	
09.00 If this hospital qualifies as a CAH or a cost prov	vider are	1.00 N	2.00 N		3.00 N	4.00 N	109.0
							107.0
therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy.							
therapy services provided by outside supplier? Ent						1.00	-
therapy services provided by outside supplier? Ent	ty Hospit	al Demonstrati "Y" for yes or	"N" for no.	If yes		1.00 N	110. (
therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21	ty Hospit	al Demonstrati "Y" for yes or	"N" for no.	If yes	5, as	N	110. (
 therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 	ty Hospit d? Enter 8, and Wo ipate in for this c conse to c CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir	"N" for no. ines 200 thr Community period? Ente enter the n column 2.	If yes rough 21			- 110. (-
<pre>therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration)for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 11.00 If this facility qualifies as a CAH, did it partic Health Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services;</pre>	ty Hospit d? Enter 8, and Wo ipate in for this c conse to c CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir	Community period? Enter the column 2. s; and/or "C"	If yes rough 21	5, as 1.00 N	N 2.00	-
<pre>therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 1.00 If this facility qualifies as a CAH, did it partic Health Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-health services.</pre>	ty Hospit d? Enter 8, and Wo ipate in for this c conse to c CAH is pa "B" for a	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds	Community period? Enternet column 2. s; and/or "C"	If yes rough 21	5, as 1.00	N	111.(
<pre>therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration)for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 11.00 If this facility qualifies as a CAH, did it partic Health Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-health services.</pre>	ty Hospit d? Enter 8, and Wo for this c onse to c CAH is pa "B" for a Rural Hea ent cost r 1. If c in partici	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the	Community period? Enter the column 2. s; and/or "C"	If yes rough 21	5, as 1.00 N	N 2.00	111.(
 therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 1.00 If this facility qualifies as a CAH, did it partic Heal th Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-heal th services. 2.00 Did this hospital participate in the Pennsylvania (PARHM) demonstration for any portion of the curre period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital bega demonstration. In column 3, enter the date the ho participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Hea Transformation (CHART) model for any portion of th reporting period? Enter "Y" for yes or "N" for no. 	ty Hospit d? Enter 8, and Wo conse to c CAH is pa "B" for a Rural Hea ent cost r n 1. If c in partici pospital ce alth Acces	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural	Community period? Enternet column 2. s; and/or "C"	If yes rough 21	5, as 1.00 N	N 2.00	111.0
 therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting perio complete Worksheet E, Part A, lines 200 through 21 applicable. 11.00 If this facility qualifies as a CAH, did it partic Health Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-health services. 12.00 Did this hospital participate in the Pennsylvania (PARHM) demonstration for any portion of the curre period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital bega demonstration. In column 3, enter the date the ho participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Hea Transformation (CHART) model for any portion of th reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" in column 1. If column 1 is yes, enter the method in column 2. If column 2 is "E", enter in column 3 for short term hospital or "98" percent for long t psychiatric, rehabilitation and long term hospital 	ty Hospit d? Enter 8, and Wo cipate in for this c ponse to c CAH is pa "B" for a Rural Hea ent cost r 1. If c n partici pspital ce lith Access he current for yes o used (A, e ither " erm care s provide	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (incl udes	Community period? Enternet column 2. s; and/or "C"	If yes rough 21	5, as 1.00 N	N 2.00 3.00	_
 therapy services provided by outside supplier? Ent for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Communi Demonstration) for the current cost reporting period complete Worksheet E, Part A, lines 200 through 21 applicable. 11.00 If this facility qualifies as a CAH, did it partic Heal th Integration Project (FCHIP) demonstration f "Y" for yes or "N" for no in column 1. If the resp integration prong of the FCHIP demo in which this Enter all that apply: "A" for Ambulance services; for tele-heal th services. 12.00 Did this hospital participate in the Pennsylvania (PARHM) demonstration for any portion of the curre period? Enter "Y" for yes or "N" for no in column "Y", enter in column 2, the date the hospital bega demonstration. In column 3, enter the date the ho participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Hea Transformation (CHART) model for any portion of th reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" in column 1. If column 2 is "E", enter the method in column 2. If column 2 is "E", enter the reporting for short term hospital or "98" percent for long the second /li>	ty Hospit d? Enter 8, and Wo for this c conse to c CAH is pa "B" for a Rural Hea ent cost r n 1. If c in partici spital ce lith Acces he current for yes o used (A, beither " erm care s provide 1. Enter "Y"	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds I th Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	Community period? Enternet column 2. s; and/or "C" 1.00 N	If yes rough 21	5, as 1.00 N	N 2.00 3.00	111. (111. (112. (113. (

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	Fr	eriod: com 01/01/2022 12/31/2022	Worksheet S Part I	
	Tc	12/31/2022	Date/Time Pr 5/26/2023 4:	
	Premi ums	Losses	Insurance	
	1.00	2. 00	3.00	_
.01List amounts of malpractice premiums and paid losses:	46, 637	3, 044		0118.0
		1.00	2.00	_
. 02 Are malpractice premiums and paid losses reported in a cost center other	than the	1.00 N	2.00	118.0
Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. . 00 DO NOT USE THIS LINE				119.0
 00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA \$3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no. 	(" for yes or he Outpatient	Ν	Ν	120. (
.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	0	Y		121.
00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente the Worksheet A line number where these taxes are included.		Ν		122. (
00Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no.	and/or			123. (
If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated org located in a CBSA outside of the main hospital CBSA? In column 2, enter " "N" for no.	jani zati ons			
Certified Transplant Center Information . 00Does this facility operate a Medicare-certified transplant center? Enter	"Y" for ves	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare-certified kidney transplant program, enter the cert	5			126.
in column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare-certified heart transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			127.
.00 If this is a Medicare-certified liver transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			128.
.00 If this is a Medicare-certified lung transplant program, enter the certif in column 1 and termination date, if applicable, in column 2.				129.
 00 If this is a Medicare-certified pancreas transplant program, enter the ce date in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare-certified intestinal transplant program, enter the 				130. 131.
date in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare-certified islet transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			132.
. 00 Removed and reserved				133.
.00 If this is a hospital-based organ procurement organization (OPO), enter t in column 1 and termination date, if applicable, in column 2. All Providers	he OPO number			134.
0.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruc	e office costs	Y	15H032	140.
1.00 2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through the office and enter the home office contractor name and contractor number.	ough 143 the na	me and address	of the home	
. 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name WISCONSIN PHYSIC SERVICE	I ANS Contractor	's Number: 0810	1	141.
00 Street: 10501 CORPORATE DRIVE PO Box: 5600	7		F	142.
. OO City: FORT WAYNE State: IN	Zip Code:	4684	5	143.
			1.00	
.00 Are provider based physicians' costs included in Worksheet A?			Y	144.
		1.00	2.00	_
.00 If costs for renal services are claimed on Wkst. A, line 74, are the cost inpatient services only? Enter "Y" for yes or "N" for no in column 1. If no, does the dialysis facility include Medicare utilization for this cost	column 1 is	1.00	2.00	145.
 period? Enter "Y" for yes or "N" for no in column 2. 00 Has the cost allocation methodology changed from the previously filed cost Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 	st report?	N		146.

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLE	PARKVIEW L EX IDENTIFICATION DATA		Provider CC	N: 15-1323		i od:	u of Form CMS Worksheet S-	
					Fro To	om 01/01/2022 12/31/2022	Part I Date/Time Pr	onarod
					10	12/31/2022	5/26/2023 4:	
							1.00	
47.00 Was there a change in the statist							N	147.0
48.00 Was there a change in the order o					6		N	148.00
49.00Was there a change to the simplif	ed cost finding meth	od? Ente					N Title VIV	149.0
			Part A 1.00	Part E 2.00	>	Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies f	for an ex			icati			
or charges? Enter "Y" for yes or								
55. 00Hospi tal			N	N	<u>D. (0</u>	N N	N	155.0
56.00 Subprovi der – IPF			N	N		N	N	156.0
57.00 Subprovider - IRF			N	N		N	N	157.0
58. 00 SUBPROVI DER					1			158.0
59. 00 SNF			N	N	1	N	Ν	159.0
60.00HOME HEALTH AGENCY			N	N		N	Ν	160.0
61.00CMHC				N		Ν	Ν	161.0
							1.00	
Multicampus							••	
65.00 Is this hospital part of a Multic	ampus hospital that h	as one o	or more camp	uses in di	fferer	nt CBSAs?	N	165.0
Enter "Y" for yes or "N" for no.	Name	(County	State	7: 0 0	ode CBSA	FTE/Campus	_
	0		1.00	2.00	Zip Co 3.00		5. 00	-
66.00 If line 165 is yes, for each	0		1.00	2.00	3.0	4.00		0166.0
campus enter the name in column							0.0	0100.0
0, county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
	_						1.00	
Health Information Technology (HI						Act		-
67.00 Is this provider a meaningful use							Y	167.0
68.00 If this provider is a CAH (line 1) reasonable cost incurred for the				e 107 IS	r), e	enter the		168.0
68.01 If this provider is a CAH and is				r qualify	for a	hardshi n		168.0
exception under §413.70(a)(6)(ii)						nai usin p		100.0
69.00 If this provider is a meaningful						'), enter the	0.0	0169.0
transition factor. (see instruction		,				,, , , , , , , , , , , , , , , , , , , ,		
						Begi nni ng	Endi ng	
						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR	beginning date and en	ding dat	e for the r	eporti ng				170.0
period respectively (mm/dd/yyyy)								
								_
						1.00	2.00	0 4 7 4 -
		or indiv	uduale opro	undin		N		0 171.00
71.00 If line 167 is "Y", does this pro								-
71.00 f line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col	reported on Wkst. S-3	, Pt. I,	line 2, co	I. 6? Ente				

OSPI T	Financial Systems PARKVIEW LAGRA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-1323	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2022 To 12/31/2022		
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI	EMENT QUESTION	NAI RE			
	General Instruction: Enter Y for all YES responses. Enter I mm/dd/yyyy format.	N for all NO r	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to th	e beginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in					1.0
			Y/N	Date	V/I	
		-	1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.	Program? If mn 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00 . 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	for Compiled, ailable in	Y	A	03/24/2022	4.0
. 00	those on the filed financial statements? If yes, submit re-		IN IN			5.0
			•	Y/N	Legal Oper.	
	F			1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	3	s the provide			6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.		wed during th	ne N		7.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio	ns.		N N		9.0
0. 00	Was an approved Intern and Resident GME program initiated	or renewed in	the current	Ν		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than	I& Pin an An	nroved	Ν		11.0
1.00	Teaching Program on Worksheet A? If yes, see instructions.	тактпапар	proved	IN		11.0
					Y/N	
					1.00	
	Bad Debts					_
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			ost reporting	Y N	12.0 13.0
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsur-	ance amounts w	aived? If yes	s, see	Ν	14.0
	instructions.					_
	Bed Complement Did total beds available change from the prior cost report	ing period? If	ves see ins	tructions	N	15.0
0.00			- <u>yes, see ma</u> -t A		t B	10.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	<u>PS&R Data</u> Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	04/30/2023	Y	04/30/2023	16.0
	date of the PS&R Report used in columns 2 and 4 .(see instructions)	, NI		N		17,
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.0
8.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		Ν		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		Ν		19. (

	Financial Systems PARKVIEW LAGRA		CN: 15-1323 F	In Lie Period:	u of Form CMS-: Worksheet S-2	
			F	From 01/01/2022 To 12/31/2022	Part II	epared:
			iption	Y/N	Y/N	
	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.0
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPLTALS)	<u>.</u>	1.00	
	Capital Related Cost		noor rikeoy			
23.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ng the cost	N N	22.0 23.0
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entero If yes, see instructions	ed into during	this cost rep	orting period?	Ν	24.0
5.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	lfyes, see	Ν	25.0
. 00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.		•	•	Ν	26.0
Į	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	Ν	27.0
	Interest Expense Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into du	ring the cost	reporti ng	N	28. (
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	Ν	29.0
	Has existing debt been replaced prior to its scheduled matu instructions.	5	5		Ν	30.0
	Has debt been recalled before scheduled maturity without is instructions. Purchased Services	ssuance of new	debt? If yes,	see	N	31.0
2.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru		ed through con	tractual	Ν	32.0
	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	plied pertaini	ng to competit	ive bidding? If	Ň	33. (
	Provider-Based Physicians Were services furnished at the provider facility under an a	arrangement wi	th provider-ba	sed physicians?	Y Y	34.
	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	0	·		N	35.
	physicians during the cost reporting period? If yes, see in	nstructions.		1		
				Y/N 1.00	 2.00	
	Home Office Costs			1.00	2.00	
6.00	Were home office costs claimed on the cost report?			Y		36.0
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?	Y		37.
8.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			Ν		38.
9.00	If line 36 is yes, did the provider render services to othe see instructions.			Ν		39.
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	Ν		40. (
		1	00	2.	00	-
	Cost Report Preparer Contact Information	I		Z.		
1.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHANNON		ECENBARGER		41.0
2.00	respectively. Enter the employer/company name of the cost report preparer.	PARKVI EW HEALT	TH SYSTEM, INC.			42.0
		N/A		SHANNON. ECENBA	RGER@PARKVI EW.	43.0

Health Financial Systems	PARKVI EW LAGRAI	NGE HOSPITAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provider CCN: 15-1323	Period:	Worksheet S-2	
				Part II Date/Time Pre	pared:
				5/26/2023 4:0	2 pm
	-				
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the ti		REIMBURSEMENT DI RECTOR			41.00
held by the cost report preparer in column	ns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cos	st report				42.00
preparer.					
43.00 Enter the telephone number and email addre	ess of the cost				43.00
report preparer in columns 1 and 2, respec	cti vel y.				

HOSPI TAL	nancial Systems AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PARKVIEW LAGRAI AL DATA	Provi der C	CN: 15-1323	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/26/2023 4:0	
						I/P Days / O/P Visits /	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Trips Title V	
		1.00	2.00	3. 00	4.00	5.00	
PA	NRT I – STATISTICAL DATA	1.00	2.00	0.00	1.00	0.00	
	ospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 12	25 54, 216. 00	0	1.0
8	exclude Swing Bed, Observation Bed and						
	ospice days)(see instructions for col. 2						
	or the portion of LDP room available beds)						
	MO and other (see instructions)						2.0
	MO I PF Subprovi der						3.0
	MO IRF Subprovider					0	4.0
	ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF					0	6.0
	otal Adults and Peds. (exclude observation		25	9, 12	25 54, 216. 00	0	7.0
	eds) (see instructions)		20	2, 12	20 04,210.00	0	'.'
	NTENSI VE CARE UNI T						8.
. 00 C0	DRONARY CARE UNI T						9.
D. 00 BL	JRN INTENSIVE CARE UNIT						10.
	JRGI CAL INTENSI VE CARE UNI T						11.
	THER SPECIAL CARE (SPECIFY)						12.
	JRSERY	43.00				0	
	otal (see instructions)		25	9, 12	25 54, 216. 00	0	
	AH visits					0	
	JBPROVI DER – I PF JBPROVI DER – I RF	,					16. 17.
	JBPROVI DER						18.
	KILLED NURSING FACILITY						19.
	JRSING FACILITY						20.
	THER LONG TERM CARE						21.
2.00 H	DME HEALTH AGENCY						22.
	MBULATORY SURGICAL CENTER (D. P.)						23.
	DSPI CE						24.
	OSPICE (non-distinct part)	30.00					24.
	MHC - CMHC						25.
		89.00				0	26. 26.
	EDERALLY QUALIFIED HEALTH CENTER otal (sum of lines 14-26)	89.00	25			0	26.
	oservation Bed Days		25			0	
	nbul ance Trips					0	29.
	mployee discount days (see instruction)						30.
	nployee discount days - IRF						31.
	abor & delivery days (see instructions)		0		0		32.
	otal ancillary labor & delivery room						32.
	utpatient days (see instructions)						
	TCH non-covered days						33.
	TCH site neutral days and discharges		_			_	33.
4.UU Te	emporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PARKVIEW LAGRAN	Provi der C	CN: 15-1323	Period:	u of Form CMS-2 Worksheet S-3	
105111	AL AND HOST TAL HEALTH GARE COMILER STATISTIC			F	From 01/01/2022 To 12/31/2022	Part I	
					10 12/31/2022	5/26/2023 4:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA				-1		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	465	65	2, 259	2		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)	617	220				2.00
3.00	HMO IPF Subprovi der	017	220				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	205	0	458	3		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	200	0	49			6.00
7.00	Total Adults and Peds. (exclude observation	670	65	2,766			7.00
	beds) (see instructions)			_,			
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	389			13.00
14.00	Total (see instructions)	670	78			165.89	
15.00	CAH visits	4, 792	751	29, 203	3		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00							18.00
19.00 20.00	SKILLED NURSING FACILITY						19.00 20.00
20.00	NURSING FACILITY OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			34	1		24.00
25.00	CMHC - CMHC			0			25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	(0.00	0.00	
27.00	Total (sum of lines 14-26)				0.00	165.89	
28.00	Observation Bed Days		11	1, 056	5		28.00
29.00	Ambul ance Trips	1					29.00
30.00	Employee discount days (see instruction)			ç	9		30.00
31.00	Employee discount days - IRF			(31.00
32.00	Labor & delivery days (see instructions)	0	3	152	2		32.00
32.01	Total ancillary labor & delivery room			() 		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0	_				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	(34.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PARKVLEW LAGRANG AL DATA	Provider C	CN: 15-1323	Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 5/26/2023 4:0	parec
		Full Time		Di s	charges		
	Company	Equi val ents	T: +1 - 1/	Title XVIII	Title XIX		
	Component	Nonpai d Workers	Title V		II LI E XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1	71 16	971	1.0
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			10	90 108		2.
. 00	HMO I PF Subprovi der				0		3.
. 00	HMO I RF Subprovi der				0		4.
. 00	Hospital Adults & Peds. Swing Bed SNF						5.
00	Hospital Adults & Peds. Swing Bed NF						6.
00	Total Adults and Peds. (exclude observation						7.
00	beds) (see instructions)						8.
00	INTENSIVE CARE UNIT						9.
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY						13
I. 00	Total (see instructions)	0,00	0	1-	71 16	971	14
5.00	CAH visits	0100	0				15.
b. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
3. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPICE						24
. 10	HOSPICE (non-distinct part)						24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	0.00					26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00 0.00					26
. 00 . 00	Total (sum of lines 14-26) Observation Bed Days	0.00					27
. 00	Ambul ance Trips						20
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days (see first detron)						31
. 00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)						``
3. 00	LTCH non-covered days				0		33
3. 01	LTCH site neutral days and discharges				0		33
4.00	,						34.

Heal th	Financial Systems PARKVIEW LAGRANGE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
			CN: 15-1323	Period: From 01/01/2022	Worksheet S-1	0
				To 12/31/2022		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by Li	ne 202 colum	n 8)	0. 234951	1 1.00
	Medicaid (see instructions for each line)	uou og it	110 202 001 0	,	01201701	1
2.00	Net revenue from Medicaid				1, 869, 982	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al payment	s from Medic	ai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicai	d		0	
6.00	Medi cai d charges				10, 365, 528	
7.00	Medicaid cost (line 1 times line 6)		<u> </u>		2, 435, 391	7.00
8.00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)			nes 2 and 5; if	565, 409	8.00
0 00	Children's Health Insurance Program (CHIP) (see instructions for	each lin	ie)		(0.7(0	
9.00 10.00	Net revenue from stand-alone CHIP				60, 768	•
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				350, 950 82, 456	•
12.00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 mi	nus line Q.	if < zero then	21, 688	•
12.00	enter zero)				21,000	12.00
	Other state or local government indigent care program (see instr					
	Net revenue from state or local indigent care program (Not inclu				2, 707, 636	
14.00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	12, 777, 809	14.00
15 00	10) State en legal indigent care program cost (line 1 times line 14)	、 、			2 002 150	15 00
15.00 16.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indi	no 15 minus line	3, 002, 159 294, 523			
10.00	13; if < zero then enter zero)	gent care			274, 323	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	o and stat	e/local indi	gent care progra	ams (see	
17.00	Private grants, donations, or endowment income restricted to fur	nding char	rity care		0	17.00
18.00	Government grants, appropriations or transfers for support of he	ospital op	oerati ons		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent	care program	s (sum of lines	881, 620	19.00
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)	I		2.00	0.00	
20.00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	2, 919, 32	3 689, 306	3, 608, 629	20.00
21.00	Cost of patients approved for charity care and uninsured discour instructions)	nts (see	685, 89	8 689, 306	1, 375, 204	21.00
22.00	Payments received from patients for amounts previously written of charity care	off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		685, 89	8 689, 306	1, 375, 204	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient	t days bey	ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		care progra	m's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see inst				3, 779, 975	
	Medicare reimbursable bad debts for the entire hospital complex				213, 850	
27.01 28.00	Medicare allowable bad debts for the entire hospital complex (see	ee instruc	crons)		329, 001 3, 450, 974	•
28.00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expe	anco (coo	i netructi one)	3, 450, 974 925, 961	•
29.00 30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	130 (300		/	2, 301, 165	•
	Total unreimbursed and uncompensated care cost (line 19 plus lir	ne 30)			3, 182, 785	
		/			,,,	

		PARKVI EW LAGRAN				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1323	Period: From 01/01/2022	Worksheet A	
					To 12/31/2022		
	Cost Center Description	Sal ari es	Other	Total (col.	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 555, 876	1, 555, 87	6 -320, 328	1, 235, 548	1.00
1.00	00101 EMS WEST STATION		0,000,070		0 2, 935		1
2.00	00200 CAP REL COSTS-MVBLE EQUIP		19, 688				2.00
2.01	00201 EMS WEST STATION EQUIP.		0		0 0		1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 461, 120	3, 732, 414	5, 193, 53	4 0	5, 193, 534	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	893, 789	12, 899, 391	13, 793, 18	0 -41, 826	13, 751, 354	5.00
7.00	00700 OPERATION OF PLANT	367, 981	836, 400	1, 204, 38	1 0	1, 204, 381	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	84, 338	84, 33	8 0	84, 338	8.00
9.00	00900 HOUSEKEEPI NG	332, 433	69, 969			402, 402	9.00
10.00	01000 DI ETARY	552, 681	391, 279	943, 96	0 -668, 504	275, 456	10.00
11.00	01100 CAFETERI A	0	0		0 667, 350		
13.00	01300 NURSI NG ADMI NI STRATI ON	437, 218	479	437,69			
	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	-	
15.00	01500 PHARMACY	583, 887	70, 813				
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
~~~~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000.0/5	1 044 045	0 ( 05 40	0 044 404	0 (01 000	1 00 00
	03000 ADULTS & PEDIATRICS	2, 389, 065	1, 246, 365				
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		0 190, 237	190, 237	43.00
50.00	05000 OPERATING ROOM	810, 451	1, 578, 545	2, 388, 99	6 0	2, 388, 996	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	810, 451	1, 578, 545		0 753, 894		
53.00	05300 ANESTHESI OLOGY	0	0		0 755, 894	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	934, 867	609, 853		0		1
60.00	06000 LABORATORY	0	1, 288, 468			1, 288, 468	1
65.00	06500 RESPI RATORY THERAPY	337, 437	147, 028				
66.00	06600 PHYSI CAL THERAPY	496, 441	11,044				
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 191, 106		
68.00	06800 SPEECH PATHOLOGY	0	0		0 107, 149		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	433, 536	433, 53			
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 248, 024		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	986, 781	986, 78			
76.97	07697 CARDI AC REHABI LI TATI ON	48, 424	2, 196	50, 62	0 0	50, 620	76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				-1	. <u></u>	_
90.00	09000 CLI NI C	0	0		0 0		
90.01	09001 LI FEBRI DGE SENI OR CARE	192, 065	58, 100				
91.00	09100 EMERGENCY	1, 157, 682	2, 255, 688	3, 413, 37	0 0	3, 413, 370	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS		00.700	00.70		00.700	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	-20, 709	-20, 70	9 0	-20, 709	95.00
112 00	11300 I NTEREST EXPENSE		210 701	248, 78	4 -248, 784	0	113.00
118.00		10, 995, 541	248, 784 28, 506, 326				
110.00	NONREIMBURSABLE COST CENTERS	10, 993, 341	20, 300, 320	37, 301, 00	/	37, 301, 007	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21, 815	21, 81	5 0	21 815	190.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 755				192.00
	07950 OCCUPATI ONAL HEALTH	0	0,700		0 0		194.00
	07951 FOUNDATI ON	0	12, 193				194.01
	07952 COMMUNITY & VOLUNTEER SVCS	853	59, 693				194.03
	07954 ER PHYSICIAN	0	0		0 0		194.04
200.00		10, 996, 394	28, 603, 782	39, 600, 17			

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL	In Lieu of Form CM	S-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CCN: 15-1323	B Period: Worksheet A	4
			From 01/01/2022 To 12/31/2022 Date/Time F	Prenared
			5/26/2023	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	6.00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT	3, 317	1, 238, 865		1.00
1. 01 00101 EMS WEST STATION	0			1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-2, 199			2.00
2.01 00201 EMS WEST STATION EQUIP.	0	0		2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-4, 445, 960			5.00
7.00 00700 OPERATION OF PLANT	-4, 309			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0			8.00
9. 00 00900 HOUSEKEEPI NG	0			9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0 -290, 913			10.00
13. 00 01300 NURSING ADMINISTRATION	-290, 913			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0			14.00
15. 00 01500 PHARMACY	0			15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0			16.00
INPATIENT ROUTINE SERVICE COST CENTERS	-			
30. 00 03000 ADULTS & PEDIATRICS	-508, 684	2, 182, 615		30.00
43.00 04300 NURSERY	0	190, 237		43.00
ANCI LLARY SERVI CE COST CENTERS	1			
50. 00 05000 OPERATING ROOM	-888, 396			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0			54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	-3, 846			65.00
66. 00 06600 PHYSI CAL THERAPY	-22, 371			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0			67.00
68.00 06800 SPEECH PATHOLOGY	-22, 371			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	248, 024		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	-30, 294	956, 487		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	-683	49, 937		76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
90. 00 09000 CLINIC 90. 01 09001 LIFEBRIDGE SENIOR CARE	0			90.00 90.01
91. 00 09100 EMERGENCY	-633, 242			90.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-033, 242	2,700,120		92.00
OTHER REIMBURSABLE COST CENTERS				/2.00
95.00 09500 AMBULANCE SERVICES	0	-20, 709		95.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE	0			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 849, 951	32, 651, 916		118.00
NONREI MBURSABLE COST CENTERS		21.015		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	21, 815		190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0			192.00
194. 01 07951 FOUNDATI ON	0			194.00
194. 03 07952 COMMUNITY & VOLUNTEER SVCS	0			194.03
194. 04 07954 ER PHYSI CI AN	0			194.04
200.00 TOTAL (SUM OF LINES 118 through 199)	-6, 849, 951	32, 750, 225		200.00

Heal th	Financial Systems	I	PARKVI EW LAGRAN	GE HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN: 15-1323	Peri od:	Worksheet A-6
					From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/26/2023 4:02 pm
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
	A - Rehab Therapy Reclass					
1.00	OCCUPATI ONAL THERAPY	67.00	186, 947	4, 159		1.00
2.00	SPEECH PATHOLOGY		104, 817	<u>2, 3</u> 32		2.00
	TOTALS		291, 764	6, 491		
	B - OB Reclass					
1.00	NURSERY	43.00	165, 553	24, 684		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	656, 073	97, 821		2.00
			821, 626	122, 505		
	C - Clinic Dietician		· · · ·			
1.00	LI FEBRI DGE SENI OR CARE	90. 01	1, 154			1.00
			1, 154	₀		
	F - Cafeteria Reclass					
1.00	CAFETERI A	11.00	390, 390	276, 960		1.00
			390, 390	276,960		
	G - Insurance Reclass		· · · ·			
1.00	CAP REL COSTS-BLDG & FIXT	1.00		28, 918		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		12, 908		2.00
		+		41,826		
	I - Salary Reclass	I	i			
1.00	ADMI NI STRATI VE & GENERAL	5.00	2, 631, 243			1.00
			2, 631, 243	ō		
	K - Depreciation		_,,	-		
1.00	EMS WEST STATION	1, 01	0	2, 935		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	595,095		2.00
3.00		0.00	0	0		3.00
0.00	TOTALS — — — — —		— — — <del>ŏ</del>	598,030		0.00
	M - Interest Reclass		0	070,000		
1.00	CAP REL COSTS-BLDG & FIXT	1.00		248, 784		1.00
1.00				248, 784		1.00
	N - Implantable Medical Suppl	ios	9	240,704		
1.00	IMPL. DEV. CHARGED TO	72.00		248, 024		1.00
1.00	PATIENTS	/2.00		240, 024		1.00
		+		248,024		
500 00	Grand Total: Increases		4, 136, 177	1, 542, 620		500.00
500.00	pi anu iutai. Inci cases	I	4, 130, 177	1, 342, 020		1 500.00

Heal th	Financial Systems	F	ARKVI EW LAGRAN	GE HOSPI TAL		In Lie	u of Form CMS-25	552-10
RECLAS	SI FI CATI ONS			Provider (	CCN: 15-1323	Period:	Worksheet A-6	
						From 01/01/2022 To 12/31/2022	Date/Time Prep	ared
					-	10 12/31/2022	5/26/2023 4:02	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	<u>F.</u>		
	6.00	7.00	8.00	9.00	10.00			
	A - Rehab Therapy Reclass				i			
1.00	PHYSI CAL THERAPY	66.00	291, 764	6, 491		0		1.00
2.00		0.00	0	0		Q		2.00
	TOTALS		291, 764	6, 491				
	B - OB Reclass				1			
1.00	ADULTS & PEDIATRICS	30.00	821, 626	122, 505				1.00
2.00		+	+_			_		2.00
			821, 626	122, 505				
	C - Clinic Dietician				1			
1.00	DI ETARY	1000	<u> </u>			_		1.00
			1, 154	0				
	F - Cafeteria Reclass				1			
1.00	DI ETARY	1000	<u>390, 3</u> 90	27 <u>6, 9</u> 60				1.00
			390, 390	276, 960				
	G - Insurance Reclass				1			
1.00	ADMI NI STRATI VE & GENERAL	5.00		41, 826		12		1.00
2.00		+				12		2.00
			0	41, 826				
	I - Salary Reclass							
1.00	ADMI NI STRATI VE & GENERAL	5.00		2,631,243		_		1.00
			0	2, 631, 243				
	K - Depreciation				1			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	598, 030		9		1.00
2.00		0.00	0	0		9		2.00
3.00		0.00	0	0		9		3.00
	TOTALS		0	598, 030				
	M - Interest Reclass				1			
1.00	INTEREST EXPENSE	1 <u>13.</u> 00		24 <u>8, 7</u> 84		11		1.00
			0	248, 784				
	N - Implantable Medical Suppli				1	İ		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00		248, 024				1.00
	PATI ENT		+		ļ	4		
			0	248, 024		_		
500.00	Grand Total: Decreases		1, 504, 934	4, 173, 863			5	500.00

Heal th	Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1323		i od: m 01/01/2022 12/31/2022		pared:
				Acquisition	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	320, 702	0		0	0	0	1.00
2.00	Land Improvements	2,011,654	0		0	0	0	2.00
3.00	Buildings and Fixtures	13, 577, 442	0		0	0	320, 808	3.00
4.00	Building Improvements	29, 098	0		0	0	13, 778	4.00
5.00	Fixed Equipment	8, 994, 687	60, 818		0	60, 818	0	5.00
6.00	Movable Equipment	9, 976, 349	1, 184, 376		0	1, 184, 376	653, 728	6.00
7.00	HIT designated Assets	1, 783, 788	40, 615		0	40, 615	0	7.00
8.00	Subtotal (sum of lines 1-7)	36, 693, 720	1, 285, 809		0	1, 285, 809	988, 314	8.00
9.00	Reconciling Items	73, 925	0		0	0	11, 587	9.00
10.00	Total (line 8 minus line 9)	36, 619, 795	1, 285, 809		0	1, 285, 809	976, 727	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	320, 702	0					1.00
2.00	Land Improvements	2, 011, 654	578, 977					2.00
3.00	Buildings and Fixtures	13, 256, 634	483, 308					3.00
4.00	Building Improvements	15, 320	15, 320					4.00
5.00	Fixed Equipment	9, 055, 505	1, 535, 885					5.00
6.00	Movable Equipment	10, 506, 997	5, 942, 840					6.00
7.00	HIT designated Assets	1, 824, 403	929, 767					7.00
8.00	Subtotal (sum of lines 1-7)	36, 991, 215	9, 486, 097					8.00
9.00	Reconciling Items	62, 338	0					9.00
10.00	Total (line 8 minus line 9)	36, 928, 877	9, 486, 097					10.00
				-				

Heal th	Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 To 12/31/2022		epared:
			SL	JMMARY OF CAP	1 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	<u>MN 2, LINES 1 a</u>	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 525, 822	22, 200		0 0	7, 854	
1.01	EMS WEST STATION	0	0		0 0	0	
2.00	CAP REL COSTS-MVBLE EQUIP	0	19, 688		0 0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0		0 0	0	2.01
3.00	Total (sum of lines 1-2)	1, 525, 822			0 0	7, 854	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)	1			
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU					
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 555, 876				1.00
1.01	EMS WEST STATION	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	19, 688				2.00
2.01	EMS WEST STATION EQUIP.	0	0				2.01
3.00	Total (sum of lines 1-2)	0	1, 575, 564				3.00

Heal th	Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 Fo 12/31/2022	Date/Time Prep 5/26/2023 4:02	pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
		1.00	2.00	col . 2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FIXT	24, 659, 815	0	24, 659, 81	0. 730948	0	1.00
1.01	EMS WEST STATION	0	-		0. 000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	9, 791, 963	715, 034	9, 076, 92		0	2.00
2.01	EMS WEST STATION EQUIP.	0	ő		0. 000000		2.01
3.00	Total (sum of lines 1-2)	34, 451, 778					3.00
		ALLOCA	FION OF OTHER (	CAPITAL	SUMMARY C	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel at				
			ed Costs	through 7)			
_		6.00	7.00	8.00	9.00	10.00	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		927, 792	22, 200	1.00
1.00	EMS WEST STATION	0	-		2, 935		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		592, 896		2.00
2.01	EMS WEST STATION EQUIP.	0	0		0 0	0	2.01
3.00	Total (sum of lines 1-2)	0	0		1, 523, 623	41, 888	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11.00	12.00	13.00	instructions) 14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	252, 101	28, 918	7,85	4 0	1, 238, 865	1.00
1.01	EMS WEST STATION	0			0	2, 935	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	12, 908		0 0	625, 492	2.00
2.01	EMS WEST STATION EQUIP.	0	0	(	0 0	0	2.01
3.00	Total (sum of lines 1-2)	252, 101	41, 826	7,85	4 O	1, 867, 292	3.00

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1323	Peri od:	Worksheet A-8	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	pared:
				Expense Classification of			2 piii
			1	Fo/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00 3,317(	CAP REL COSTS-BLDG & FIXT	1.00	5.00 11	1.00
1.01	COSTS-BLDG & FIXT (chapter 2) Investment income - EMS WEST		0	EMS WEST STATION	1.01	0	1.01
	STATION (chapter 2)			LWS WEST STATION	1.01	0	
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - EMS WEST		OE	EMS WEST STATION EQUIP.	2.01	0	2.01
3.00	STATION EQUIP. (chapter 2) Investment income - other		о		0.00	0	3.00
	(chapter 2)		-				
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)						
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21)	А	2 420		7.00	0	8.00
8.00	Television and radio service (chapter 21)	A	-3, 4290	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)	A-8-2	0		0.00		
10.00	Provider-based physician adjustment	A-8-2	-2, 032, 391			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	В	-8800	OPERATION OF PLANT	7.00	0	11.00
12.00	Related organization	A-8-1	-2, 123, 144			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		-290, 9130	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
	abstracts				0.00		
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending meshines		0		0.00	0	20.00
20. 00 21. 00	Vending machines Income from imposition of		0 0		0. 00 0. 00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	OF	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0,	*** Cost Center Deleted **	* 114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26. 01	COSTS-BLDG & FIXT Depreciation - EMS WEST		OE	EMS WEST STATION	1.01	0	26.01
	STATI ON						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - EMS WEST		OE	EMS WEST STATION EQUIP.	2.01	0	27.01
28.00	STATION EQUIP. Non-physician Anesthetist		0,	*** Cost Center Deleted **	* 19.00		28.00
					1		

Heal th	Fi nan	ici al	Systems
AD.JUST	MENTS	TO	EXPENSES

ADJUSTMENTS TO EXPENSES         Provider CN: 15-1323         Period: From 01/01/2022 To 12/31/2022         Worksheet A-8 Date/Time/Propared: 5/26/2023 4: 02 pm           Cost Center Description         Basi s/Code (2)         Amount         Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted         Worksheet A Date/Time/Propared: 5/26/2023 4: 02 pm           29.00         Physicians' assistant 0. Adjustment for occupational therapy Costs in excess of limitation (chapter 14) 0.00         0.00         0.00         0.00         0.00         0.29.00           30.00         A-8-3         0         0         0.00         0.00         0.29.00         30.00         30.00         30.00           30.99         Hospic (non-distinct) (see instructions)         A-8-3         0         0         0         0.00         0.00         30.09           31.00         Adjustment for oppercharting         A-8-3         0         0         0         0.00         0.00         30.09           32.00         CAH HT Adjustment for Depreciation and Interest A         A-8-3         0         SPEECH PATHOLOGY         68.00         31.00           33.00         PFO Admin Med Dir Allocation A         2.36,852/ADMINISTRATUK & GENERAL         5.00         33.01         33.01         33.01         33.01         33.01         33.00         3	Health Financial Systems		PARKVIEW LAGRA	ANGE HUSPITAL	In Lie	U OF FORM CMS-∠	2552-10
Cost Center Description         Basi s/Code         Amount         Cost Center         Line #         Wkst. A-7           29.00         Physicians' assistant         0         0.00         4.00         5.00         90.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         0         0.00         4.00         5.00         30.00           31.00         Adjustment for speech         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00<	ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1323		Worksheet A-8	
Cost Center Description         Basi s/Code         Amount         Cost Center         Line #         Wkst. A-7           29.00         Physicians' assistant         1.00         2.00         3.00         4.00         5.00           29.00         Physicians' assistant         1.00         2.00         3.00         4.00         5.00           29.00         Physicians' assistant         0         0.00         0.00         0.00         0.00         30.00           1         1.00         2.00         3.00         4.00         5.00         29.00           30.00         Adjustment for occupational the access of limitation (chapter 14)         0         0         0.00         0.00         30.09           30.00         CAHINT Adjustment for operciation and Interest         A-8-3         0         0         0         0         0         0         0         0         0         0         30.09         33.00         30.99         31.00         33.01         0         2.00         33.00         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.01         33.03         33.02         33.03							
Cost Center Description         Basi s/Code (2)         Amount         Cost Center         Line #         Wkst. A-7           29:00         Physicians' assistant (2)         1.00         2:00         3.00         4.00         5.00           29:00         Physicians' assistant (30:00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         0         0         0.00         0.00         30:00         4.00         5.00         30:00           30:00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         0         0         0         0         0         0         30:00         30:09           31:00         Adjustment for speech parbtology costs in excess of limitation (chapter 14)         A-8-3         0         SPEECH PATHOLOGY         68:00         31:00           32:00         Depreciation and Interest 33:00         A         -5,346 AdMINISTRATIVE & GENERAL 5:00         0         0         0         0         0         0         33:00         33:00           33:01         Telemetry Monitoring 4:1:4:680/FRATINE & SENTIVE & GENERAL 5:00         5:00         33:00         33:02         33:02         33:02         33:02         33:02         33:02         33:02         33:02         33:02         33:03         33:02					10 12/31/2022		
Cost Center Description         Basis/Code (2)         Amount         Cost Center         Line #         Wkst. A-7           29.00         Physicians' assistant (1)         1.00         2.00         3.00         4.00         5.00           29.00         Adjustment for occupational therapy costs in excess of instructions)         A-8-3         0         0.00         0.00         0.00         0.29, 00           30.00         Adjustment for speech pathol gy costs in excess of limitation (chapter 14)         A-8-3         0         00CCUPATIONAL THERAPY         67.00         30.00         30.99           31.00         Adjustment for speech pathol gy costs in excess of limitation (chapter 14)         A-8-3         0         SPEECH PATHOLOGY         68.00         31.00           32.00         CAH HIT Adjustment for pathol gy costs in excess of limitation (chapter 14)         A         -5,346 AdMINISTRATIVE & GENERAL         5.00         33.00           33.00         Lobbying         A         -5,346 AdMINISTRATIVE & GENERAL         5.00         0.33.00           33.01         Telemetry Monitoring         A         -2,336,852 AdMINISTRATIVE & GENERAL         5.00         0.33.00           33.03         Miscel Ianeous Revenue         B         -14,680 PERATING ROOM         50.00         33.03           33.04				Expanse Classification	on Workshoot A	572072023 4:0	z pili
Cost Center Description         Basi s/Code (2)         Amount         Cost Center         Line #         Wkst. A-7 Ref.           29.00         Physicians' assistant therapy costs in excess of limitation (chapter 14) assistant for occupational therapy costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech pathol day costs in excess of limitation (chapter 14) assistant for speech limitation (chapter 14) assistant for speech limita							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue					s to be Aujusteu		
(2)         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           29.01         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.02         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           31.00         Adjustment for speech pathol gg costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5,346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CPG Admin Med Dir All ocation         A         24,779ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2,336,852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.06         Miscel aneous Revenue         B         -14.6880PERATI NG ROM         50.00         0         33.04           34F Fee Expense Removal         A         -2,336,852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           35.05							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue							
(2)         Construction         Ref.           29.00         Physicians' assistant         0         3.00         4.00         5.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         00CCUPATIONAL THERAPY         67.00         30.00           30.99         instructions)         A-8-3         0SPECH PATHOLOGY         68.00         30.99           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         A-8-3         0SPEECH PATHOLOGY         68.00         31.00           32.00         Lobbying         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.01         CHenetry Monitoring         A         -5.346 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.02         PPG Admin Med Di r Al location         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.03           33.04         HAF Fee Expense Removal         A         -2.336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue	Cost Center Description	Basis/Code	Amount	Cost Center	line #	Wkst A-7	
1.00         2.00         3.00         4.00         5.00           29.00         Physicians' assistant         A         0         0.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         0         0CCUPATIONAL THERAPY         67.00         30.00           30.99         Hospice (non-distinct) (see instructions)         A-8-3         0         0CCUPATIONAL THERAPY         67.00         30.00           31.00         Adjustment for speech Limitation (chapter 14)         A-8-3         0         0SPEECH PATHOLOGY         68.00         31.00           32.00         CAH HIT Adjustment for Depreciation and Interest         0         0         0.00         0         32.00           33.02         PPG Admin Med Dir Allocation A         A         -5,346 ADMINISTRATIVE & GENERAL 5.00         5.00         0         33.00           33.04         HAF Fee Expense Removal A         A         -2,336.852 ADMINISTRATIVE & GENERAL 5.00         5.00         0         33.02           33.06         Miscel Ianeous Revenue         B         -14.688 OPERATING ROOM 5.00         0         33.03         0         0         0         0         0         0         0         0         0         0         0         0         0         <			7 uno di re		Erno "		
29.00         Physicians' assistant         0         0.00         0.29.00           30.00         Adjustment for occupational therapy costs in excess of limitation (chapter 14)         A-8-3         0         00CCUPATIONAL THERAPY         67.00         30.00           30.99         Hospice (non-distinct) (see instructions)         0         0.00CUPATIONAL THERAPY         67.00         30.00           31.00         Adjustment for speech pathology costs in excess of limitation (chapter 14)         0         0         0         0.00         0         32.00           32.00         CAH HIT Adjustment for petrol adio and Interest         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td>2.00</td><td>3.00</td><td>4,00</td><td></td><td></td></t<>			2.00	3.00	4,00		
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1 imitation (chapter 14)       32.00       0       0.00       0       32.00         33.00       Lobbying       A       -5,346 ADMINISTRATIVE & GENERAL       5.00       0       33.00         33.01       Telemetry Monitoring       A       16,757 ADULTS & PEDIATRICS       30.00       0       33.01         33.02       PPG Admin Med Dir Allocation       A       24,779 ADMINISTRATIVE & GENERAL       5.00       0       33.02         33.03       Miscellaneous Revenue       B       -14,688 OPERATING ROOM       50.00       0       33.03         33.04       HAF Fee Expense Removal       A       -2,336,852 ADMINISTRATIVE & GENERAL       5.00       0       33.03         33.05       Miscellaneous Revenue       B       -14,688 OPERATING ROOM       50.00       0       33.04         33.05       Miscellaneous Revenue       B       -2,336,852 ADMINISTRATIVE & GENERAL       5.00       0       33.05         33.05       Miscellaneous Revenue       B       -683 CARDIAC REHABILITATION       76.97       0       33.06         33.06       Miscellaneous Revenue       B       -22,371 SPECH PATHOLOGY       68.00       0       33.07         33.09       Miscellaneous Revenue       B       -22,9414 DRUGS CHARGE			-				
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Depreciation and Interest         A         -5, 346 ADMI NI STRATI VE & GENERAL         5.00         0         33.00           33.00         Lobbying         A         -5, 346 ADMI NI STRATI VE & GENERAL         5.00         0         33.01           33.01         Telemetry Monitoring         A         16, 757 ADMI NI STRATI VE & GENERAL         5.00         0         33.01           33.02         PPG Admin Med Dir All ocation         A         24, 779 ADMI NI STRATI VE & GENERAL         5.00         0         33.02           33.03         Miscellaneous Revenue         B         -14, 688 OPERATI NG ROOM         50.00         0         33.04           33.04         HAF Fee Expense Removal         A         -2, 336, 852 ADMI NI STRATI VE & GENERAL         5.00         0         33.04           33.05         Miscel aneous Revenue         B         -18 ADMI NI STRATI VE & GENERAL         5.00         0         33.05           33.06         Miscel aneous Revenue         B         -683 CARDI AC REHABI LI TATI ON         76.97         0         33.06           33.07         Speech Therapy Contracted         B         -22, 371 SPEECH PATHOLOGY         68.00         0         33.09           33.09         Miscel aneous Revenue         B         -880 DRUGS CHARGED TO PATI EN			0		0.00	0	32.00
33.01       Telemetry Monitoring       A       16,757 ADULTS & PEDIATRICS       30.00       0       33.01         33.02       PPG Admin Med Dir Allocation       A       24,779 ADMINISTRATIVE & GENERAL       5.00       0       33.02         33.03       Miscellaneous Revenue       B       -14,688 OPERATING ROOM       50.00       0       33.03         33.04       HAF Fee Expense Removal       A       -2,336,852 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33.05       Miscellaneous Revenue       B       -18 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33.06       Miscellaneous Revenue       B       -2,336,852 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33.07       Speech Therapy Contracted       B       -683 CARDIAC REHABILITATION       76.97       0       33.06         33.09       Miscellaneous Revenue       B       -22,371 SPEECH PATHOLOGY       68.00       0       33.07         33.09       Miscellaneous Revenue       B       -29,414 DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33.09       Miscellaneous Revenue       B       -22,371 SPEECH PATHOLOGY       65.00       0       33.10         33.10       CKG Interpr							
33. 02       PPG Admin Med Dir Allocation       A       24,779 ADMINISTRATIVE & GENERAL       5.00       0       33.02         33. 03       Miscellaneous Revenue       B       -14,688 OPERATING ROOM       50.00       0       33.03         33. 04       HAF Fee Expense Removal       A       -2,336,852 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33. 05       Miscellaneous Revenue       B       -18 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33. 06       Miscellaneous Revenue       B       -18 ADMINISTRATIVE & GENERAL       5.00       0       33.04         33. 05       Miscellaneous Revenue       B       -683 CARDIAC REHABILITATION       76.97       0       33.06         33. 08       Pharmacy Employee Rx Purchases       B       -22,371 SPEECH PATHOLOGY       68.00       0       33.07         33. 09       Miscellaneous Revenue       B       -29,414 DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33. 10       EKG Interpretation Costs       A       -3,846 RESPI RATORY THERAPY       65.00       0       33.10         33. 11       CAH HIT ADJ Depr Carryfrwd       A       -22,371 PHYSI CAL THERAPY       66.00       0       33.12         33. 12	33.00 Lobbying	А	-5, 346	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.03       Mi scel I aneous Revenue       B       -14,688 OPERATING ROOM       50.00       0       33.03         33.04       HAF Fee Expense Removal       A       -2,336,852 ADMI NI STRATIVE & GENERAL       5.00       0       33.04         33.05       Mi scel I aneous Revenue       B       -18 ADMI NI STRATIVE & GENERAL       5.00       0       33.05         33.06       Mi scel I aneous Revenue       B       -683 CARDI AC REHABI LI TATION       76.97       0       33.06         33.07       Speech Therapy Contracted       B       -22,371 SPEECH PATHOLOGY       68.00       0       33.07         33.09       Mi scel I aneous Revenue       B       -29,414 DRUGS CHARGED TO PATI ENTS       73.00       0       33.09         33.00       Mi scel I aneous Revenue       B       -29,414 DRUGS CHARGED TO PATI ENTS       73.00       0       33.09         33.00       Mi scel I aneous Revenue       B       -29,414 DRUGS CHARGED TO PATI ENTS       73.00       0       33.09         33.10       EKG Interpretation Costs       A       -3,846 RESPI RATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -2,199 CAP REL COSTS-MVBLE EQUI P       2.00       9       33.11	33.01 Telemetry Monitoring	А	16, 757	ADULTS & PEDIATRICS	30.00	0	33.01
33.04       HAF Fee Expense Removal       A       -2, 336, 852       ADMI NI STRATI VE & GENERAL       5.00       0       33.04         33.05       Mi scel I aneous Revenue       B       -18       ADMI NI STRATI VE & GENERAL       5.00       0       33.05         33.06       Mi scel I aneous Revenue       B       -683 (CARDI AC REHABI LI TATI ON       76.97       0       33.06         33.07       Speech Therapy Contracted       B       -22, 371 SPEECH PATHOLOGY       68.00       0       33.07         33.08       Pharmacy Employee Rx Purchases       B       -29, 414 DRUGS CHARGED TO PATI ENTS       73.00       0       33.08         33.01       EKG Interpretation Costs       A       -3, 846 RESPI RATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -22, 371 PHYSI CAL THERAPY       66.00       0       33.12         33.12       Mi scel I aneous Revenue       B       -22, 371 PHYSI CAL THERAPY       66.00       0       33.12         33.12       Mi scel I aneous Revenue       B       -22, 371 PHYSI CAL THERAPY       66.00       0       33.12         33.12       Mi scel I aneous Revenue       B       -22, 371 PHYSI CAL THERAPY       66.00       0       33.1	33.02 PPG Admin Med Dir Allocation	А	24, 779	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33. 05       Mi scel I aneous Revenue       B       -18 ADMI NI STRATI VE & GENERAL       5. 00       0       33. 05         33. 06       Mi scel I aneous Revenue       B       -683 CARDI AC REHABI LI TATI ON       76. 97       0       33. 06         33. 07       Speech Therapy Contracted       B       -22, 371 SPEECH PATHOLOGY       68. 00       0       33. 07         33. 08       Pharmacy Employee Rx Purchases       B       -22, 371 SPEECH PATHOLOGY       68. 00       0       33. 07         33. 09       Mi scel I aneous Revenue       B       -29, 414 DRUGS CHARGED TO PATI ENTS       73. 00       0       33. 08         33. 09       Mi scel I aneous Revenue       B       -880 DRUGS CHARGED TO PATI ENTS       73. 00       0       33. 09         33. 10       EKG Interpretati on Costs       A       -3, 846 RESPI RATORY THERAPY       65. 00       0       33. 10         33. 11       CAH HIT ADJ Depr Carryfrwd       A       -2, 199 CAP REL COSTS-MVBLE EQUIP       2. 00       9       33. 11         2012-2016       B       -22, 371 PHYSI CAL THERAPY       66. 00       0       33. 12         33. 13       COMMUNI TY BENEFIT EXPENSE       A       -5, 379 ADMI NI STRATI VE & GENERAL       5. 00       0       33. 13       50. 00	33.03 Miscellaneous Revenue	В	-14, 688	OPERATING ROOM	50.00	0	33.03
33.06       Mi scel I aneous Revenue       B       -683 CARDI AC REHABI LI TATI ON       76.97       0       33.06         33.07       Speech Therapy Contracted       B       -22,371 SPEECH PATHOLOGY       68.00       0       33.07         33.08       Pharmacy Employee Rx Purchases       B       -29,414 DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33.09       Mi scel I aneous Revenue       B       -880 DRUGS CHARGED TO PATIENTS       73.00       0       33.09         33.10       EKG Interpretation Costs       A       -3,846 RESPI RATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -2,199 CAP REL COSTS-MVBLE EQUIP       2.00       9       33.11         2012-2016       B       -22,371 PHYSI CAL THERAPY       66.00       0       33.12         33.13       COMMUNI TY BENEFIT EXPENSE       A       -5,379 ADMI NI STRATI VE & GENERAL       5.00       0       33.13         50.00       TOTAL (sum of Lines 1 thru 49)       -6, 849, 951       -6, 849, 951       50.00       50.00       50.00	33.04 HAF Fee Expense Removal	А	-2, 336, 852	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.07       Speech Therapy Contracted       B       -22, 371       SPEECH PATHOLOGY       68.00       0       33.07         33.08       Pharmacy Employee Rx Purchases       B       -29, 414       DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33.09       Miscel Ianeous Revenue       B       -880       DRUGS CHARGED TO PATIENTS       73.00       0       33.09         33.10       EKG Interpretation Costs       A       -3,846       RESPIRATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -2,199       CAP REL COSTS-MVBLE EQUIP       2.00       9       33.11         2012-2016       B       -22,371       PHYSI CAL THERAPY       66.00       0       33.12         33.13       COMMUNI TY BENEFIT EXPENSE       A       -5,379       ADMINI STRATIVE & GENERAL       5.00       0       33.13         50.00       TOTAL (sum of Lines 1 thru 49)       -6,849,951       -6,849,951       50.00       0       33.12	33.05 Miscellaneous Revenue	В	-18	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.08       Pharmacy Employee Rx Purchases       B       -29, 414 DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33.09       Miscellaneous Revenue       B       -880 DRUGS CHARGED TO PATIENTS       73.00       0       33.09         33.10       EKG Interpretation Costs       A       -3,846 RESPIRATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -2,199 CAP REL COSTS-MVBLE EQUIP       2.00       9       33.11         2012-2016       B       -22,371 PHYSI CAL THERAPY       66.00       0       33.12         33.13       COMMUNITY BENEFIT EXPENSE       A       -5,379 ADMINISTRATIVE & GENERAL       5.00       0       33.13         50.00       TOTAL (sum of Lines 1 thru 49)       -6,849,951       -6,849,951       50.00       50.00       50.00	33.06 Mi scel I aneous Revenue	В	-683	CARDIAC REHABILITATION	76.97	0	33.06
33.08       Pharmacy Employee Rx Purchases       B       -29,414 DRUGS CHARGED TO PATIENTS       73.00       0       33.08         33.09       Miscellaneous Revenue       B       -880 DRUGS CHARGED TO PATIENTS       73.00       0       33.09         33.10       EKG Interpretation Costs       A       -3,846 RESPIRATORY THERAPY       65.00       0       33.10         33.11       CAH HIT ADJ Depr Carryfrwd       A       -2,199 CAP REL COSTS-MVBLE EQUIP       2.00       9       33.11         2012-2016       B       -22,371 PHYSI CAL THERAPY       66.00       0       33.12         Miscellaneous Revenue       B       -22,371 PHYSI CAL THERAPY       66.00       0       33.12         33.13       COMMUNITY BENEFIT EXPENSE       A       -5,379 ADMINISTRATIVE & GENERAL       5.00       0       33.13         50.00       TOTAL (sum of Lines 1 thru 49)       -6,849,951       -6,849,951       50.00       50.00       50.00	33.07 Speech Therapy Contracted	В	-22, 371	SPEECH PATHOLOGY	68.00	0	33.07
33.10EKG Interpretation CostsA-3,846RESPIRATORY THERAPY65.00033.1033.11CAH HIT ADJ Depr Carryfrwd 2012-2016A-2,199CAP REL COSTS-MVBLE EQUIP2.00933.1133.12Mi scel I aneous Revenue 33.13B-22,371PHYSI CAL THERAPY66.00033.1233.13COMMUNI TY BENEFIT EXPENSE TOTAL (sum of Lines 1 thru 49) (Transfer to Worksheet A,A-5,379ADMINI STRATI VE & GENERAL -6,849,95150.00033.13		В	-29, 414	DRUGS CHARGED TO PATIENTS	73.00	0	33.08
33. 11CAH HIT ADJ Depr Carryfrwd 2012-2016A-2, 199CAP REL COSTS-MVBLE EQUIP2.00933. 1133. 12Mi scel I aneous Revenue 33. 13B-22, 371PHYSI CAL THERAPY66.00033. 1233. 13COMMUNI TY BENEFIT EXPENSE TOTAL (sum of Lines 1 thru 49) (Transfer to Worksheet A,A-5, 379ADMI NI STRATI VE & GENERAL -6, 849, 9515.00033. 13	33.09 Mi scel Laneous Revenue	В	-880	DRUGS CHARGED TO PATIENTS	73.00	0	33.09
2012-2016       33.12       Mi scel I aneous Revenue       B       -22, 371 PHYSI CAL THERAPY       66.00       0       33.12         33.13       COMMUNI TY BENEFIT EXPENSE       A       -5, 379 ADMI NI STRATI VE & GENERAL       5.00       0       33.13         50.00       TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,       -6, 849, 951       -6, 849, 951       50.00       50.00	33.10 EKG Interpretation Costs	А	-3, 846	RESPI RATORY THERAPY	65.00	0	33.10
33.12         Miscellaneous Revenue         B         -22,371         PHYSICAL THERAPY         66.00         0         33.12           33.13         COMMUNITY BENEFIT EXPENSE         A         -5,379         ADMINISTRATIVE & GENERAL         5.00         0         33.13           50.00         TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,         -6,849,951         -6,849,951         50.00         50.00	33.11 CAH HIT ADJ Depr Carryfrwd	А	-2, 199	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.13         COMMUNITY BENEFIT EXPENSE         A         -5, 379         ADMINISTRATIVE & GENERAL         5.00         0         33.13           50.00         TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,         -6, 849, 951         -6, 849, 951         50.00         50.00							
50.00         TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,         -6,849,951         50.00	33.12 Mi scel I aneous Revenue	В	-22, 371	PHYSI CAL THERAPY	66.00	0	33.12
(Transfer to Worksheet A,	33.13 COMMUNITY BENEFIT EXPENSE	А	-5, 379	ADMINISTRATIVE & GENERAL	5.00	0	33.13
(Transfer to Worksheet A,	50.00 TOTAL (sum of lines 1 thru 49)		-6, 849, 951				50.00
column 6, line 200.)	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

A. Costs - If cost, find daring appreciate overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	PARKVI EW LAGR	IEW LAGRANGE HOSPITAL In Lie			2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1323	Period: From 01/01/2022	Worksheet A-8	3-1
OFFICE	To 12/31/2022 Date/Time P 5/26/2023 4					
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Allocation	7, 676, 922	6, 277, 377	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Related Party Subsidy Adj.	0	3, 522, 689	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			7, 676, 922	9, 800, 066	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas no	t been posted to worksneet A,	corumns r and/or 2,	the amount allowable si	nould be indicated in col	umn 4 or this part			
				Rel ated Organi zati on(s)	and/or Home Office			
				5				
	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 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	В	0.00 Parkview Health System, Inc.	100.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00	G. Other (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 organi zati on.

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 provi der.

Health Financial Systems	PARKVI EW LAGRANGE	HOSPI TAL	In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFLCE COSTS	M RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1323	Period: From 01/01/2022	Worksheet A-8-1
UTTEE COSTS				Date/Time Prepared:

								5/26/20	<u>23 4: C</u>	<u>)2 pm </u>
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS	A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS (	OR CLAIMED	HOME	
	OFFICE COSTS:									
1.00	1, 399, 545	0								1.00
2.00	-3, 522, 689	0							1	2.00
3.00	0	0							1	3.00
4.00	0	0								4.00
5.00	-2, 123, 144									5.00

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

1103 1101	been posted to worksheet A,	cordinas r and/or 2, the amount arrowable should be rhareated rh cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4		
	6,00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	sement under title XVIII.	
6.00	Home Office	6.00
7.00		7.00
8.00 9.00		8.00
9.00		9.00
10. 00 100. 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.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Heal th	Financial Syste	ems	PARKVI EW LAGR	ANGE HOSPITAL		In Li	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	IAN ADJUSTMENT		Provider (	CCN: 15-1323	Period: Worksheet A-8-2		8-2
						From 01/01/202		
						To 12/31/2022		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/26/2023 4:0 Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	KGL AMOUTT	ider Component	
		rdentifier	Kellurier att on	Component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1 00		EMPLOYEE BENEFITS DEPARTMENT	3.00	4.00		0.00		1.00
1.00		EMPLOYEE BENEFIIS DEPARIMENT	Ŭ	-				
2.00	0.00		0	-			-	
3.00		ADULTS & PEDIATRICS	525, 441			0 0		
4.00		OPERATING ROOM	873, 708	873, 708			0	
5.00		LIFEBRIDGE SENIOR CARE	0	0		0 C	0 0	
6.00		EMERGENCY	1, 971, 000	633, 242	1, 337, 75	B C	0	
7.00	0.00		0	0		0 C	0	7.00
8.00	0.00		0	0		D C	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		ol c	0 0	10.00
200.00			3, 370, 149	2,032,391	1, 337, 75	В	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
				2	Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	0.00					1.00
2.00	0, 00		0					
3.00		ADULTS & PEDIATRICS	0					
4.00		OPERATING ROOM		0				
4.00 5.00		LIFEBRIDGE SENIOR CARE	0					
			0	e e e e e e e e e e e e e e e e e e e				
6.00		EMERGENCY	0	0			0	
7.00	0.00		0	0			0	
8.00	0.00		0	0		0 0	-	
9.00	0.00		0	0		oj c	0	7.00
10.00	0.00		0	0		0  C	0	
200.00			0	0		0 0	00	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	)	1.00
2.00	0.00		0	0		o c		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0		525, 441		3.00
4.00		OPERATING ROOM	l o	l o		0 873, 708		4.00
5.00		LI FEBRI DGE SENI OR CARE	0	0 O				5.00
6.00		EMERGENCY	n	0		633, 242		6.00
7.00	0. 00		0	, i i i i i i i i i i i i i i i i i i i				7.00
8.00	0.00							8.00
9.00	0.00			0				9.00
9.00 10.00	0.00			0   0				9.00
200.00	I		0	I 0	I	2, 032, 391	1	200.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1323	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/26/2023 4:0	
			CAPITAL R	ELATED COSTS	0/20/2020 1.0	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	EMS WEST STATI ON	MVBLE EQUIP	EMS WEST STATI ON EQUI P.	
	0	1.00	1.01	2.00	2.01	
1. 00 00100 CAP REL COSTS-BLDG & FLXT	1, 238, 865	1, 238, 865	1			1.00
1.01 00101 EMS WEST STATION	2, 935	0	2, 93			1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP	625, 492			625, 492 0	C	2.00
2.01 00201 EMS WEST STATION EQUIP. 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5, 193, 534	0		0 0		
5. 00 00500 ADMI NI STRATI VE & GENERAL	9, 305, 394	270, 460		0 136, 549	0	
7.00 00700 OPERATION OF PLANT	1, 200, 072	66, 713		0 33, 683	C	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	84, 338			0 1, 926	0	•
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	402, 402	12, 483		0 6, 303	0	
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	275, 456 376, 437	50, 084 0		0 25, 287 0 0	0	
13. 00 01300 NURSING ADMINI STRATI ON	437, 697	0		0 0	C C	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	23, 791		0 12,012	0	
15. 00 01500 PHARMACY	654, 700	20, 474		0 10, 337	0	
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	4, 040		0 2,040	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	2, 182, 615	264, 351	1	0 133, 469	C	30.00
43. 00 04300 NURSERY	190, 237	3, 980		0 133, 409	0	
ANCI LLARY SERVI CE COST CENTERS	170,207	0,700		2,010		10.00
50. 00 05000 OPERATI NG ROOM	1, 500, 600	150, 674		0 76, 074	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	753, 894	18, 815		0 9, 500	0	
53. 00 05300 ANESTHESI OLOGY	1 544 700	0		0 0 0 37,702	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 544, 720 1, 288, 468	74, 674 32, 113		0 37, 702 0 16, 214	0	
65. 00 06500 RESPIRATORY THERAPY	480, 619			0 4, 552	0	
66.00 06600 PHYSI CAL THERAPY	186, 859	20, 594		0 10, 398	0	
67.00 06700 OCCUPATI ONAL THERAPY	191, 106	18, 800		0 9, 492	0	
68.00 06800 SPEECH PATHOLOGY	84, 778	10, 538		0 5, 321	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	185, 512	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	248, 024 956, 487	0		0 0		
76. 97 07697 CARDI AC REHABI LI TATI ON	49, 937	10, 584		0 5,344	C C	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS			1	-	-	
90. 00 09000 CLINIC 90. 01 09001 LIFEBRIDGE SENIOR CARE	0 251, 319	0 13, 720		0 0 0 6,927	0	
91. 00 09100 EMERGENCY	2, 780, 128			0 53, 292	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,700,120	100,000		00,272	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	-20, 709	0	2, 93	35 0	0	95.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE			1			112 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	32, 651, 916	1, 185, 268	2, 93	5 598, 432	0	113.00 118.00
NONREI MBURSABLE COST CENTERS	) 32,031,710	1, 103, 200	2,70	570, 432		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 815	3, 362		0 1, 697		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 755	50, 235		0 25, 363		192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0		0 0		194.00
194. 01 07951 FOUNDATI ON 194. 03 07952 COMMUNI TY & VOLUNTEER SVCS	12, 193 60, 546	0		0 0		194.01 194.03
194. 03 07952 COMMONTRY & VOLUNTEER SVCS 194. 04 07954 ER PHYSI CLAN	60, 546	0		0 0		194.03
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	32, 750, 225	1, 238, 865	2, 93	625, 492	0	202.00

		PARKVI EW LAGRAN				u of Form CMS-2	2552-1
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/26/2023 4:0	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI E & GENERAL		LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT						1 1 0
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
2.00	00200 CAF KEE COSTS-MUBBLE LOUTP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 193, 534					4.0
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 504, 734	11, 217, 137	11, 217, 13	37		5.0
7.00	00700 OPERATION OF PLANT	157,080	1, 457, 548				7.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	90, 078			146, 338	
9.00	00900 HOUSEKEEPI NG	141, 906	563, 094			0	
10.00	01000 DI ETARY	68, 785	419, 612			0	
11.00	01100 CAFETERI A	166, 646	543, 083			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	186, 636	624, 333			0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	35, 803			0	
15.00	01500 PHARMACY	249, 244	934, 755			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	247, 244	6, 080			0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0,000	5,10	7,731	0	10.0
30.00	03000 ADULTS & PEDI ATRI CS	669, 094	3, 249, 529	1, 691, 36	649, 725	49, 413	30.0
43.00	04300 NURSERY	70, 670	266, 897			549	
45.00	ANCI LLARY SERVICE COST CENTERS	70,070	200,077	130, 71	7,705	547	
50.00	05000 OPERATI NG ROOM	345, 958	2,073,306	1, 079, 14	370, 329	41, 555	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	280, 059	1,062,268			2, 175	
53.00	05300 ANESTHESI OLOGY	200,007	1,002,200		0 0	2,1,0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	399, 068	2,056,164		-	15, 752	
60.00	06000 LABORATORY	0	1, 336, 795			0	
65.00	06500 RESPI RATORY THERAPY	144, 042	638, 229			0	
66.00	06600 PHYSI CAL THERAPY	87, 371	305, 222			0	
67.00	06700 OCCUPATI ONAL THERAPY	79, 802	299, 200			0	
68.00	06800 SPEECH PATHOLOGY	44, 743	145, 380			0	68.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	185, 512			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	248, 024			0	
	07300 DRUGS CHARGED TO PATIENTS	0	956, 487			0	
76.97	07697 CARDI AC REHABI LI TATI ON	20, 671	86, 536				
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	i		1	<u> </u>		
90.00	09000 CLI NI C	0	0		0 0	0	90.0
90.01	09001 LI FEBRI DGE SENI OR CARE	82, 480	354, 446	184, 48	33, 720	0	90.0
91.00	09100 EMERGENCY	494, 181	3, 433, 151	1, 786, 94	259, 423	36, 894	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.0
	OTHER REIMBURSABLE COST CENTERS	l l		ı			
95.00	09500 AMBULANCE SERVI CES	0	-17, 774		0 0	0	95.0
	SPECIAL PURPOSE COST CENTERS			ı			
113. OC	11300 INTEREST EXPENSE						1113.0
118.00		5, 193, 170	32, 570, 895	11, 123, 79	2, 084, 465	146, 338	118.0
	NONREI MBURSABLE COST CENTERS						1
190. OC	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 874	13, 98	8, 263	0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	o	79, 353				192.0
	07950 OCCUPATI ONAL HEALTH	o	0		0 0		194.0
	07951 FOUNDATI ON	o	12, 193				194.0
	07952 COMMUNITY & VOLUNTEER SVCS	364	60, 910				194.0
			,				194.0
194.03	07954 ER PHYSICIAN	O	()		0 0	0	
194. 03 194. 04		0	0		0 0		
194.03	Cross Foot Adjustments	0	0		0 0		200. 0

Health Financial Systems	PARKVI EW LAGRAN	IGE HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre	pared:
			045575014		5/26/2023 4:0	2 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
				N	SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS				1 1		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 EMS WEST STATION 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP.						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	886, 864	011 202				9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A	50, 167 0	811, 282 0	825, 756			10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	42, 036			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	23, 830	0	(,, C		136, 741	14.00
15.00 01500 PHARMACY	20, 508	0	49, 869	0	4, 412	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	4, 047	0		0	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2(4, 700	011 000	170.070	202.020	2 501	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	264, 788 3, 987	811, 282 0	179, 372 14, 012		2, 581 3, 087	30.00 43.00
ANCI LLARY SERVICE COST CENTERS	5, 707	0	14,012	27,711	5,007	43.00
50.00 05000 OPERATI NG ROOM	150, 924	0	88, 076	187, 941	41, 649	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 847	0	55, 613	3 118, 787	12, 233	52.00
53.00 05300 ANESTHESI OLOGY	0	0	C	, u	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	74, 798	0	117, 058		9, 093	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	32, 166 9, 031	0	38, 990		0 4, 360	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	20, 629	0	45, 953		4, 300	66.00
67.00 06700 OCCUPATI ONAL THERAPY	18, 832	0	19, 843		191	67.00
68.00 06800 SPEECH PATHOLOGY	10, 556	0	9, 922	2 0	95	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	-	19, 730	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	-	26, 355	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 97 07697 CARDI AC REHABI LI TATI ON	0 10, 601	0 0	0 8, 181	, u	0 81	73.00 76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	10, 001	0	0, 101		0	
OUTPATIENT SERVICE COST CENTERS	1	-		·, -,		
90. 00 09000 CLINIC	0	0	C		0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	13, 742	0	29, 417		125	
91.00 09100 EMERGENCY	105, 725	0	127, 327	271, 799	12, 251	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			/V		,0.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	833, 178	811, 282	825, 669	991, 332	136, 466	118.00
NONREI MBURSABLE COST CENTERS	0.010				10/	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 368 50, 318	0				190. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	50, 318	0				192.00
194. 01 07951 FOUNDATI ON	0	0				194.00
194. 03 07952 COMMUNI TY & VOLUNTEER SVCS	0	0	87			194.03
194. 04 07954 ER PHYSI CI AN	0	0	C	0 0	0	194.04
200.00 Cross Foot Adjustments	_	_	-		-	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0 811, 282	005 754	991, 332	0 136, 741	201.00
202.00 TOTAL (SUM TIMES TTO UNDURIN 201)	886, 864	011, 282	825, 756	991, 332	130, 741	202.00

Health Fi	nancial Systems	PARKVI EW LAGRAM	IGE HOSPI TAL		In Lieu	u of Form CMS-	2552-10
COST ALLC	DCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1323	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/26/2023 4:0	epared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
1.00     00       1.01     00       2.00     00       2.01     00	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT						1.00 1.01 2.00 2.01 4.00
5.00 009 7.00 00 8.00 009 9.00 009 10.00 010	500 ADMI NI STRATI VE & GENERAL 700 OPERATI ON OF PLANT 800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG 000 DI ETARY						5.00 7.00 8.00 9.00 10.00
13.00 013 14.00 014 15.00 014	100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY	1, 546, 401 0	23, 223	3			11.00 13.00 14.00 15.00 16.00
I NF	PATIENT ROUTINE SERVICE COST CENTERS					7 007 000	
43.00 043	000 ADULTS & PEDIATRICS 300 NURSERY	0	6, 403 474			7, 287, 288 467, 685	1
	CILLARY SERVICE COST CENTERS	0	711	4, 033, 63	88 0	4, 033, 638	50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY	0	C	1, 869, 07		1, 869, 074 0	52.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C 000 LABORATORY	0	4, 798 C	3, 531, 42	22 0	3, 531, 422 2, 143, 685	54.00
65.00 06!	500 RESPI RATORY THERAPY	0	C	1, 044, 96	5 0	1, 044, 965	65.00
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	0	1, 117 232			582, 628 540, 238	
	800 SPEECH PATHOLOGY	0	74			267, 599	
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C			301, 800	
	200 I MPL. DEV. CHARGED TO PATIENTS	0	C			403, 474	
	300 DRUGS CHARGED TO PATI ENTS 697 CARDI AC REHABI LI TATI ON	1, 546, 401 0	C			3, 000, 736 176, 454	
	700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	0	1
	TPATIENT SERVICE COST CENTERS			1	-		
	000 CLINIC 001 LIFEBRIDGE SENIOR CARE	0	C		0 0 88 0	0 615, 938	
	100 EMERGENCY	0	9, 414			6, 042, 926	
	200 OBSERVATION BEDS (NON-DISTINCT PART	_	.,		0	-, ,	92.00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES ECIAL PURPOSE COST CENTERS	0	C	-17,7	0	-17, 774	95.00
	300 INTEREST EXPENSE			1			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 546, 401	23, 223	32, 291, 7	76 0	32, 291, 776	
	NREIMBURSABLE COST CENTERS			50.(1			100.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0	C			52, 629 294, 531	190.00 192.00
	950 OCCUPATI ONAL HEALTH	0	C	)	0 0		194.00
194.0107	951 FOUNDATI ON	0	C	18, 53			194.01
	952 COMMUNITY & VOLUNTEER SVCS	0	C	92, 75			194.03
200.00	954 ER PHYSICIAN Cross Foot Adjustments	0	C				194.04 200.00
201.00	Negative Cost Centers	0	C		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 546, 401	23, 223	32, 750, 22	25 0	32, 750, 225	202.00

Health Financial Systems	PARKVI EW LAGRAN	IGE HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod:	Worksheet B	
			F	rom 01/01/2022	Part II Date/Time Pre	nared
					5/26/2023 4:0	2 pm
			CAPI TAL REI	LATED COSTS		
Cost Center Description	Directly	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	
cost center bescription	Assigned New	DLUG & FIAI	STATI ON	WVDLE EQUIP	STATION	
	Capi tal		STATION		EQUI P.	
	Related Costs					
	0	1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS				I		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 EMS WEST STATION						1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201 EMS WEST STATION EQUIP. 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	2.01 4.00
5.00 00500 ADMI NI STRATI VE & GENERAL	0	270, 460	0	136, 549	0	5.00
7. 00 00700 OPERATION OF PLANT	1, 044, 851	66, 713	0		0	7.00
8.00 00800 LAUNDRY & LI NEN SERVICE	0	3, 814	0		0	
9.00 00900 HOUSEKEEPI NG	0	12, 483	0		0	9.00
10. 00 01000 DI ETARY	0	50, 084	0	25, 287	0	10.00
11. 00 01100 CAFETERI A	0	0	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	23, 791	0		0	14.00
15.00 01500 PHARMACY	0	20, 474	0		0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	4, 040	0	2, 040	0	16.00
30. 00 03000 ADULTS & PEDIATRICS	0	264, 351	0	133, 469	0	30.00
43. 00 04300 NURSERY	0	3, 980	0		0	43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	5, 700	0	2,010	0	43.00
50. 00 05000 OPERATI NG ROOM	0	150, 674	0	76, 074	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	18, 815	0		0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	74, 674	0	37, 702	0	54.00
60. 00 06000 LABORATORY	0	32, 113	0		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	9, 016	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	20, 594	0		0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	18,800	0		0	67.00 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	- 0	10, 538 0	0	5, 321 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	0	0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	10, 584	0		0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0		0	77.00
OUTPATIENT SERVICE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
90. 00 09000 CLINIC	0	0	0		0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	13, 720	0		0	90.01
91.00 09100 EMERGENCY	- 0	105, 550	0	53, 292	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	2, 935	0	0	95.00
SPECIAL PURPOSE COST CENTERS	V	0	2,733	9	0	/3.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 1, 044, 851	1, 185, 268	2, 935	598, 432	0	118.00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 1	3, 362	0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	50, 235	0	25, 363		192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	0	0	0	0		194.01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194.03 194.04
194.04 07954 ER PHYSICIAN 200.00 Cross Foot Adjustments	0	0	0	0		200.00
201.00 Negative Cost Centers		0	Ω	0		200.00
202.00 TOTAL (sum Lines 118 through 201)	1, 044, 851	1, 238, 865	2, 935	625, 492	0	201.00
· · · · · · · · · · · · · · · · · · ·	.,,	,,,	_,	, ., -	Ū	

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1323	Period: From 01/01/2022 To 12/31/2022		narod.
					10 12/31/2022	5/26/2023 4:0	12 pm
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI E & GENERAL		LAUNDRY & LINEN SERVICE	
		2A	4.00	5.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 EMS WEST STATION						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 EMS WEST STATION EQUIP.						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	C				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	407, 009	C				5.00
7.00	00700 OPERATION OF PLANT	1, 145, 247	C	21/01			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 740	C			12, 402	
9.00	00900 HOUSEKEEPI NG	18, 786	C			0	
10.00	01000 DI ETARY	75, 371	C			0	
11.00	01100 CAFETERI A	0	C			0	11. OC
13.00	01300 NURSING ADMINISTRATION	0	C			0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	35, 803	C	-		0	14.00
15.00	01500 PHARMACY	30, 811	C			0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	6, 080	C	1 1	5, 255	0	16. OC
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	397, 820	C			4, 187	30.00
43.00	04300 NURSERY	5, 990	C	5,04	11 5, 177	47	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	226, 748	C			3, 522	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	28, 315	C			184	•
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	112, 376	C			1, 335	
60.00	06000 LABORATORY	48, 327	C			0	
65.00		13, 568	C			0	65.00
66.00	06600 PHYSI CAL THERAPY	30, 992	C			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	28, 292				0	67.00
68.00	06800 SPEECH PATHOLOGY	15, 859	C	=, ,		0	68.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	-			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	.,		0	72.00
73.00 76.97	07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON	15, 928	C			0	73.00
77.00		15, 928	C			0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	U	L	/	0 0	0	1 / /. 00
90.00	09000 CLINIC	0	C	1	0 0	0	90.00
90.00	09001 LI FEBRI DGE SENI OR CARE	20, 647	C		-	0	90.00
91.00	09100 EMERGENCY	158, 842	C			3, 127	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 842	C	04, 0	137,202	5, 127	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	U					72.00
95.00	09500 AMBULANCE SERVICES	2, 935	C	1	0 0	0	95.00
<del>7</del> 5.00	SPECIAL PURPOSE COST CENTERS	2, 935	C	′′	0 0	0	95.00
113 00	11300 I NTEREST EXPENSE	1					113.00
118.00		2, 831, 486	C	403, 62	1, 103, 064	12, 402	118 00
110.00	NONREIMBURSABLE COST CENTERS	2,001,400	C	403,02		12, 402	1 10.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 059	С С	50		0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	75, 598		1,49			192.00
	07950 OCCUPATI ONAL HEALTH	13, 390	0		0 00,007		194.00
	07950 OCCOPATIONAL HEALTH			23			194.00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0					194.01
	07954 ER PHYSI CI AN	0		1,13			194.03
200.00		0	L.	1		0	200.00
200. UL		U					200.00
201.00	Negative Cost Centers		C			∩	1201 00

ALLOCATION OF CAPITAL RELATED COSTS         Provider CDE: 15-132         Provider CDE: 15-132		Financial Systems	PARKVI EW LAGRAN	GE_HOSPITAL		In Lieu	u of Form CMS-2	2552-10
Cost Center Description         HOUSEKEEPING         OIETARY         CAFETERIA         NUESUNG         5/20/2023 4:02 pm           ISTINERAL SERVICE COST CENTERS         9.00         10.00         11.00         13.00         14.00         5/R01CES 4           ISTINERAL SERVICE COST CENTERS         9.00         10.00         11.00         13.00         14.00           1.01         001010 GAP REL COSTS ANDALE BOUP P         2.00         2.00         2.00         2.00           0.00010 GAP REL COSTS ANDALE BOUP P         2.01         5.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         0.00201 DELS MIST STATION E0LIP         2.00         5.00         0.00         5.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider CC		rom 01/01/2022	Part II	
Cost Center Description         HOUSEKEEPING         DIETARY         CAFETERIA ADMINISTRATION         CRETERIA SUPPLY           1:00         GNIOD CAP PEL COSTS-BLOG & FIXT         1.00         11.00         11.00         11.00         11.00         11.00           1:00         GNIOD CAP PEL COSTS-BLOG & FIXT         1.01         0.010 EW SEST STATION         1.01           2:00         02000 CAP PEL COSTS-BLOG & FIXT         1.00         1.00         1.00           2:00         02000 CAP PEL COSTS-BLOG & FIXT         1.01         0.010 CAP PEL COSTS-BLOG & FIXT         1.00           2:00         02000 CAP PEL COSTS-BURGE STATION         0.010         0.0100 CAP PEL COSTS-BURGE STATION         2.01           0:00 0000 DEMUCYE BENETS TATION EDUIP.         0.010.02         0.0100.00         0.010.0257         1.00           1:00 01000 DETAMINISTRATION         0.020         0.022         1.2.31         1.00           1:00 01000 DETAMINISTRATION         0.022         1.2.31         1.00         1.0.00           1:00 01000 DETAMINISTRATION         0.022         1.2.31         1.00         1.00         1.0.02         1.2.33         1.00           1:00 01000 DETAMINISTRATION         0.022         1.2.31         0.022         1.2.31         0.022         1.2.31         0.0					T	o 12/31/2022		
Unit         N         SUPPLY           0         0         0         10.00         13.00         14.00           10         00100 CAP FEL         0.051 SRUG 6 # FLT         1.00         1.00         1.00           10         00100 CAP FEL         0.051 SRUG 6 # FLT         1.00         1.00         1.00           10         00100 CAP FEL         0.051 SRUG 6 # FLT         1.00         1.00         1.00           10         00100 CAP FEL         0.051 SRUG 6 # FLT         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.01         0.0		Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A		CENTRAL	
ENERGAL SERVICE COST CENTERS         9.00         10.00         11.00         13.00         14.00           1.00         GOUDD CAP REL COST S-BLOG A FIXT         1.00         1.00         1.00         1.00         1.00         1.00           1.00         GOUDD CAP REL COST S-BLOG A FIXT         1.01         1.01         1.01         1.01         1.01         1.01         2.00         1.01         2.00         1.01         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         7.00         2.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         1.0.01         10.0257         1.1.00         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         110.01         10.01								
1.00       00100_CAP_REL_COSTS_BLOE & FLXT       1.01         010       00101       Bas WEST_STATION       1.01         2.00       00200_CAP_REL_COSTS_HABLE_EOUP       2.01         4.00       00400_EMPLOYEF BERNET TS_DEPARTMENT       5.00         5.00       00500_GPERATION OF PLANT       6.00         6.00       00400_EMPLOYEF BERNET TS_DEPARTMENT       5.00         5.00       00000_GPERATION OF PLANT       6.00         000000_CAPT REL_COSTS_HABLE_COST       7.00         010000_GPERATION OF PLANT       6.00         010000_GPERATION OF PLANT       6.00         011000_UTERAP       8.100         011000_UTERAP       8.100         011000_UTERAP       9.00         011000_UTERAP       8.100         011000_UTERAP       9.00         01100			9.00	10.00	11.00			
1. 01 0001 EAS MEST STATION			1					
2.00         00200 CAP. REL. COSTS-AWBLE FOULP         2.00           2.01         00200 EAPLOYEE BUNETITS TON EQUIP.         4.00           4.00         00400 EMPLOYEE BUNETITS DEPARTINIT         5.00           5.00         00500 AMMINISTRATION E QUIP.         4.00           0.00         00400 EMPLOYEE BUNETITS DEPARTINIT         7.00           0.00         00000 AMMINISTRATION E QUIP.         45.657           0.00         00000 HETARY         2.983           0.00         00000 HETARY         2.983           0.00         0000 CHIRAL SERVICE         45.657           0.00         0000 CHIRAL SERVICES & SUPLY         1.227           0.00         0         0         68.649           1.00         01500 PHARMACY         1.056         0         10.0257           0.00         0000 AULTS & SEDRAY         2.02         1.74         32.22           0.01         0000 AULTS & SEDRAY         2.02         0.717         32.34         20.077           0.03000 AULTS & SEDRAY         2.05         0         1.74         32.2         1.59           43.00         04300 AULTS & SEDRAY         2.02         0.500         1.954         1.926           0.03000 AULTS & SEDRAY         7.770 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
2. 01         00201 EMS VEST STATION EQUIP.         2. 01         2. 01         2. 01           4. 00         00400 EMPLOVEE ENERTIS DEPARTITIONT         5. 00         00500 ADMINISTRATIVE & GENERAL         7. 00           7. 00         007500 ADMINISTRATIVE & GENERAL         7. 00         7. 00           8. 00         008000 LAURDRY & LINEN SERVICE         9. 00         9. 00           9. 00         009000 LAURDRY & LINEN SERVICE         9. 00         10. 00           10. 00         0100 CAFTERIA NO         0         10. 257         12. 313           11. 00         0100 CAFTERIA NO ROLES & SUPLY         1, 221         0         0         0. 2. 216           15. 00         01300 NURSING ADMINISTRATION         0         0         2. 212         15. 00           15. 00         01400 MEDICAL RECORDS & LIPBRAY         1. 208         0         10. 02         2. 212         15. 00           30. 00         03000 ADULTS & PEDIATRIC SOST CENTERS         10. 43. 45. 0         4. 56. 54. 00         50. 00           50. 00         05200 OPENATI ING ROM         7. 77         0         1. 454         0         4. 565         54. 00           50. 00         05200 DELLISE MERSON         7. 77         0         0         0         53. 00								
4.00         00000 EMPLOYEE EMERTITS DEPARTMENT         4.00           5.00         00500 ADMINISTRATION OF PLANT         7.00           0.00         00000 DETARY         2.50           0.00         00000 DETARY         2.53           1.00         0100 CAFETERIA         9.00           0.00         00000 DETARY         2.533         151,020           0.00         0100 CAFETERIA         0         0         522           1.00         0.00         00000 MERIS MS ADMINISTRATION         0         0         522           1.00         0.100 CAFETERIA         0         0         0         2.21         13.00           1.00         0.100 CAFETERIA         SUPPLY         1,227         0         0         0         2.01         16.00           0.100 OMERIA MS ADMINISTRATION         0         0         2.21         15.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00								
5. 00         000500         ANM IN STRATT VE & GEMERAL.         7.00         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700         0700								
7.00         00700         0PERATION OF PLANT         8.00         03000         AUMORY & LINEN SERVICE         8.00           9.00         00900         HUSKEEPI NG         45.657         9.00         10.257         9.00           11.00         01100 CATETRI A         0         0         0.252         12.313         11.00           13.00         01300 CHAUSKEEPI NG         0.552         12.313         11.00         13.00           13.00         01300 CHAUSKEEPI NG         0.00         0         0         0         13.00           14.00         01400 CHAURAL SERVICE S & SUPPLY         1,227         0         0         0         0         0         13.00           15.00         01500 HEDICAL RECORDS & LIBRARY         2.08         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0								
8. 00         003000 LAUNDRY & LINEN SERVICE         4         5         9         00         90         00000 HUDSEKEPING         45,657         9         9         00         00000 HUDSEKEPING         45,657         9         9         00         00000 HUDSEKEPING         45,657         9         00         00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<								
10.00         01000 DI LTARY         2.583         151,020         10.00           11.00         0100 CAFTERIA         0         0         0.527         1.3.00           13.00         01300 NURSING ADMINI STATION         0         0         522         12.313         13.00           14.00         01400 CENTRAL SERVICES & SUPPLY         1,227         0         0         0         2.215         15.00           16.00         DISOD (PERICAL RECORDS & LI BEARY         208         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8.00</td></t<>								8.00
11.00       0100       CAPTERIA       10       0       10.257       11.00         13.00       01400       ONNESING ADMINISTRATION       0       0       522       12.313       68.649       14.00         15.00       01500       NESING ADMINISTRATION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	9.00	DO900 HOUSEKEEPI NG	45, 657					9.00
13.00       01300       NURSI NG ADMIN IN STRATION       0       0       522       12.31       13.00         14.00       01400       015.00       OCOND CENTRAL SERVICES & SUPPLY       1,227       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	10.00	D1000 DI ETARY	2, 583	151, 020				10.00
14.00       0       0       0       68.649       14.00         15.00       0       15.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>10, 257</td> <td>7</td> <td></td> <td>11.00</td>			0	0	10, 257	7		11.00
15.00       01500       PHARMACY       1,056       0       619       0       2,215       15.00         16.00       IMPATI ENT ROUTINE_SERVICE COST CENTERS			-	0				
16. 00         O1600/ MEDICAL RECORDS & LIBRARY         208         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O				0				
INPATIENT ROUTINE SERVICE COST CENTERS           0.00         00000 ADULTS & PEDIATRICS         13,633         151,020         2,229         4,756         1,2663         43.00           43.00         043000 RUBERY         151,020         2,229         4,756         1,2663         43.00           43.00         04300 RUBERY         151,020         174         372         1,550         43.00           43.00         05000 OPERATING ROOM         7,770         0         1,094         2,334         20,907         50.00           50.00         05000 ANESTHES IOLOGY         0         0         0         0         0         53.00           54.00         05400 RAIDILOGY-DIAGNESTIC         3,851         0         1,454         0         4,565         54.00           0.00         0.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				-				
30. 00       03000       AULTS & PEDIATRICS       13, 633       151, 020       2, 229       4, 756       1, 296       30. 00         43. 00       04300       NUMESERY       205       0       174       372       1, 550       43. 00         50. 00       05000       OPERATING ROOM       7, 770       0       1, 094       2, 334       20, 907       50. 00         52.00       05000       PERATING ROOM       770       0       691       1, 475       6, 142       52. 00         53.00       05300       RADENTHESI OLOGY       0       0       0       0       53. 00         64.00       0600 RADIOLOGY DIAGNOSTIC       3, 851       0       1, 454       0       4, 565       54. 00         65.00       06000 RESPIRATORY       1, 656       0       484       0       2, 189       65. 00         66.00       06600 RESPIRATORAL THERAPY       1, 062       0       571       0       112       66. 00         71.00       0123       0       484       0       2, 189       65. 00       67. 00       67. 00       68. 00       0       0       0       0       72. 00       72. 00       72. 00       72. 00       73. 00			208	0	(	0	0	16.00
43.00         Dot 04300         NURSERY         205         0         174         372         1,550         43.00           ANCILLARY SERVICE COST CENTERS         0         0         1,094         2,334         20,907         50.00           50.00         05000 OPERATING ROOM         970         0         691         1,175         6,142         52.00           50.00         05000 AUSTHESTISIOLOGY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			12 (22)	151 020	2.220	4 754	1 204	20.00
ANCILLARY SERVICE COST CENTERS           00         00000 (PERATING ROOM         7,770         0         1,094         2,334         20,907         50.00           52.00         05300 (DELIVERY ROOM & LABOR ROOM         970         0         691         1,475         6,142         52.00           53.00         05300 (ANESTHESI OLGY-DI AGNOSTIC         3,351         0         1,454         0         4,665         54.00         0         0         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         77.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></td<>								•
50.00         OFSOOD         OPERATING ROOM         7,770         0         1,094         2,334         20,907         50.00           52.00         OS2000         DEL/EVR ROOM & LABOR ROOM         970         0         691         1,475         6,142         52.00           53.00         OS300         ANESTHESI OLOGY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			205	U	174	572	1, 550	43.00
52.00         D5200         DELIVERY ROOM & LABOR ROOM         970         0         691         1,475         6,142         52.00           53.00         D5300         ANESTHESI OLOGY         0         0         0         0         0         0         0         53.00           54.00         D5400         RADI OLOGY-DI AGNOSTI C         3,851         0         1,454         0         4,565         54.00           05.00         D6500         RSDE TADRY THERAPY         1,656         0         0         0         0         0         60.00           65.00         D6500         D6500         D500         D500         D510         0         0         0         112         66.00           66.00         D6600         SPECCH PATHOLOCY         543         0         123         0         44         68.00           0         D0         0         0         0         0         0         13.231         72.00         73.00           72.00         D700         MELICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         0         77.00         77.00         77.00         77.00         77.00         77.00         77.00         <			7, 770	0	1.094	2,334	20.907	50.00
53. 00         00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
60.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td></td> <td></td> <td>•</td>			0	0	C			•
65.00       06500       RESPIRATORY THERAPY       465       0       444       0       2, 189       65.00         66.00       06600       PHYSICAL THERAPY       1, 062       0       571       0       112       66.00         67.00       05700       0CCUPATIONAL THERAPY       969       0       246       0       96       67.00         68.00       06800       SPEECH PATHOLOGY       543       0       123       0       48       68.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       9,905       171.00         72.00       07200       INPL. DEV. CHARGED TO PATIENTS       0       0       0       13.22       0       46       69.67.07         70.00       07300       ALGGENEIC STEM CELL ACOUISITION       546       0       102       0       13.23       72.00       73.00         70.00       07700       ALGGENEIC STEM CELL ACOUISITION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td>54.00</td><td>05400 RADI OLOGY-DI AGNOSTI C</td><td>3, 851</td><td>0</td><td>1, 454</td><td>0</td><td>4, 565</td><td>54.00</td></td<>	54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 851	0	1, 454	0	4, 565	54.00
66.00       06600       PHYSI CAL THERAPY       1,062       0       571       0       112       66.00         67.00       06700       0CCUPATI IONAL THERAPY       969       0       246       0       96       67.00         68.00       06800       SPEECH PATHOLOGY       543       0       123       0       48       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       9,905       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       73.00         73.00       07300       DRUSC CHARGED TO PATIENTS       0       0       0       0       73.00         76.97       70677       CARDIA C REHABILI TATI ON       546       0       102       0       41       76.97         77.00       700       700       76.97       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <	60.00	D6000 LABORATORY	1, 656	0	C	0	0	60.00
67.00       06700       0CCUPATI ONAL THERAPY       969       0       246       0       96       67.00         68.00       06800       SPEECH PATHOLOCY       543       0       123       0       48       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       9,905       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       9,905       71.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       0       0       73.00         76.97       07697       CARDI AC REHABILITATI ON       546       0       102       0       17.00         07700       ALLOGENEIC STEM CELL ACQUISITION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0				0			2, 189	•
68.00       06800       SPEECH PATHOLOGY       543       0       123       0       48       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       9, 905       71.00         72.00       07200       INPL       DEV. CHARGED TO PATI ENTS       0       0       0       0       13, 231       72.00       73.00       73.00       73.00       0       0       0       0       73.00       73.00       73.00       0       0       0       0       0       73.00       73.00       73.00       73.00       73.00       0       0       0       0       0       73.00       73.00       73.00       73.00       73.00       73.00       0       0       0       0       0       0       0       73.00       73.00       73.00       73.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0				°,				
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       0       9,905       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       13.23       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       13.23       72.00         76.97       CARDIAC REHABILITATION       546       0       102       0       41       76.97         77.00       O7700 ALLOGENEIC STEM CELL ACQUISITION       0       0       0       0       0       0       70.00         00000       CLINIC       COST CENTERS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       13,231       72.00         73.00       D7300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <				0				•
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.00         76.97       76.97       CARDIAC REHABILITATION       546       0       102       0       41       76.97         77.00       OT700       ALLOGENEIC STEM CELL ACQUISITION       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0				0				
76.97         07697         CARDI AC REHABILITATION         546         0         102         0         41         76.97           77.00         ALLOGENEIC STEM CELL ACQUISITION         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				0	-	-		
77.00       OTOO       ALLOGENEIC STEM CELL ACQUISITION       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O       O <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
OUTPATIENT SERVICE COST CENTERS           90.00         09000 CLINIC         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<								•
90.00         09000         CLINIC         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0				0		,		//.00
91.00       09100       EMERGENCY       5,443       0       1,582       3,376       6,151       91.00       92.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       92.00       92.00       92.00       92.00         0       09500       AMBURANCE SERVICES       0       0       0       0       92.00         95.00       09500       AMBULANCE SERVICES       0       0       0       0       95.00         SPECIAL PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       10.256       12.313       68.511       118.00       118.00       10.250       10.250       10.250       10.250       10.	-		0	0	C	0	0	90.00
92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       92.00         0THER       REI MBURSABLE       COST CENTERS       95.00       0       0       0       0       0       95.00         95.00       OP500       AMBULANCE       SERVICES       0       0       0       0       0       95.00         95.00       OP500       AMBULANCE       SERVICES       0       0       0       0       0       95.00         113.00       INTEREST       EXPENSE       0       10,256       12,313       68,511       118.00         118.00       SUBTOTALS       (SUM OF LINES 1 through 117)       42,894       151,020       10,256       12,313       68,511       118.00         118.00       NONRE IMBURSABLE       COST CENTERS       113.00       10,256       12,313       68,511       118.00         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       173       0       0       0       68       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       2,590       0       0       0       194.00         194.00       07950       OCCUPATI ONAL HEALTH       0       0       0       0       194	90.01	09001 LI FEBRI DGE SENI OR CARE	707	0	365	0	63	90.01
OTHER         REI MBURSABLE         COST         CENTERS           95.00         OPSOO         AMBULANCE         SERVI CES         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td>91.00</td><td>D9100 EMERGENCY</td><td>5, 443</td><td>0</td><td>1, 582</td><td>3, 376</td><td>6, 151</td><td>91.00</td></t<>	91.00	D9100 EMERGENCY	5, 443	0	1, 582	3, 376	6, 151	91.00
95.00         OP500         AMBULANCE SERVICES         0         0         0         0         0         0         0         0         0         0         95.00           SPECIAL PURPOSE COST CENTERS           113.00         INTREEST EXPENSE         113.00         INTREST EXPENSE         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         100.00         100.0								92.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           113.00         INTEREST EXPENSE           SUBTOTALS (SUM OF LINES 1 through 117)         42,894           151,020         10,256           12,313         68,511           118.00         NONREI MBURSABLE COST CENTERS           190.00         IFT, FLOWER, COFFEE SHOP & CANTEEN           192.00         19200           192.00         PHYSI CI ANS' PRI VATE OFFICES           200         00           194.00         07950           0000         0           194.01         07951           194.01         0           194.02         0           194.03         07952           COMUNITY & VOLUNTEER SVCS         0           0         0           194.04         07954           194.04         07954           200.00         Cross Foot Adjustments           200.00         0           201.00         Negative Cost Centers						· · · · · ·		
113.00       11300       INTEREST EXPENSE       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.00       100.00       104.00       104.00       104.00       104.01       104.01       104.01       104.01       104.			0	0	0	0	0	95.00
SUBTOTALS (SUM OF LINES 1 through 117)         42,894         151,020         10,256         12,313         68,511         118.00           NONREI MBURSABLE COST CENTERS         10000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         173         0         0         68,511         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         2,590         0         0         0         45         192.00           194.00         07950         OCCUPATI ONAL HEALTH         0         0         0         0         194.00           194.01         07951         FOUNDATI ON         0         0         0         194.00           194.01         07952         COMMUNITY & VOLUNTEER SVCS         0         0         0         194.01           194.03         07952         COMMUNITY & VOLUNTEER SVCS         0         0         194.03         194.03           194.04         07954         ER PHYSI CI AN         0         0         0         194.04           200.00         Cross Foot Adjustments         0         0         0         0         200.00           201.00         Negati ve Cost Centers         0         0         0         0         201.00						1		
NONREI MBURSABLE COST CENTERS           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         173         0         0         68         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         2,590         0         0         0         45         192.00           194.00         07950         OCCUPATI ONAL HEALTH         0         0         0         0         194.00           194.01         07951         FOUNDATI ON         0         0         0         194.01           194.01         07952         COMMUNITY & VOLUNTEER SVCS         0         0         0         194.03           194.03         07952         COMMUNITY & VOLUNTEER SVCS         0         0         194.03         194.04         25         194.03           194.04         07954         ER PHYSI CI AN         0         0         0         0         194.04           200.00         Cross Foot Adjustments         200.00         0         0         201.00			42,004	151 000	10 254	10 010	(O E11	
190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       173       0       0       68       190.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       2,590       0       0       0       45       192.00         194.00       07950       OCCUPATI ONAL HEALTH       0       0       0       0       194.00         194.01       07951       FOUNDATI ON       0       0       0       0       194.01         194.03       07952       COMMUNITY & VOLUNTEER SVCS       0       0       1       0       25       194.03         194.04       07954       ER PHYSI CLAN       0       0       0       0       0       194.04         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negati ve Cost Centers       0       0       0       0       201.00			42, 894	151, 020	10, 250	D 12, 313	08, 311	1118.00
192.00       PHYSI CI ANS' PRI VATE OFFICES       2,590       0       0       45       192.00         194.00       07950       OCCUPATI ONAL HEALTH       0       0       0       0       194.00         194.01       07951       FOUNDATI ON       0       0       0       0       194.01         194.03       07952       COMMUNITY & VOLUNTEER SVCS       0       0       1       0       25       194.03         194.04       07954       ER PHYSI CI AN       0       0       0       0       0       194.04         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negati ve Cost Centers       0       0       0       0       201.00			172	0	(		Q.A	190 00
194.00       07950       OCCUPATI ONAL HEALTH       0       0       0       0       194.00         194.01       07951       FOUNDATI ON       0       0       0       0       194.01         194.01       07952       COMMUNITY & VOLUNTEER SVCS       0       0       1       0       25       194.03         194.04       07954       ER PHYSI CI AN       0       0       0       0       0       0       194.04         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00				0	(			
194.01       07951       FOUNDATION       0       0       0       194.01         194.03       07952       COMMUNITY & VOLUNTEER SVCS       0       0       1       0       25       194.03         194.04       07954       ER PHYSICIAN       0       0       0       0       194.04         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0			2, 370	0	(	0		
194.03       07952       COMMUNITY & VOLUNTEER SVCS       0       0       1       0       25       194.03         194.04       07954       ER PHYSICIAN       0       0       0       0       194.04         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00			l o	o	C	o o		•
194.04         07954         ER PHYSI CLAN         0         0         0         194.04           200.00         Cross Foot Adjustments         0         0         0         0         194.04           201.00         Negative Cost Centers         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> <td>25</td> <td>194.03</td>			0	0	1	0	25	194.03
201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 201.00	194.04		0	0	C	0		194.04
202.00   101AL (sum lines 118 through 201)   45,657  151,020  10,257  12,313  68,649 202.00			0	0	C	0		
	202.00	IUIAL (sum lines 118 through 201)	45, 657	151, 020	10, 257	12, 313	68, 649	202.00

	Financial Systems	PARKVI EW LAGRANO				u of Form CMS-	-2552-10
ALLOCAT	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1323	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pr 5/26/2023 4:	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						1 1 00
1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 2.00
	00201 EMS WEST STATION EQUIP.						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
							11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	78, 984					14.00
	01600 MEDICAL RECORDS & LIBRARY	70, 904 0	11, 658				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	U	11,000				10.00
	03000 ADULTS & PEDI ATRI CS	0	3, 214	983, 35	51 0	983, 35	1 30.00
	04300 NURSERY	Ő	238	18, 79		18, 794	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	357	497, 86	50 0	497, 860	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	82, 31	11 0	82, 31	1 52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	(	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 409	261, 94		261, 946	
1	06000 LABORATORY	0	0	116, 99		116, 99	
	06500 RESPI RATORY THERAPY	0	0	40, 48		40, 486	
	06600 PHYSI CAL THERAPY	0	561	65, 84		65, 848	
	06700 OCCUPATI ONAL THERAPY	0	117	59, 82		59, 823	
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	37 0	33,06		33, 063	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	13, 40 17, 91		13, 409 17, 915	
	07300 DRUGS CHARGED TO PATIENTS	78, 984	0	97, 04		97, 048	
	07697 CARDI AC REHABI LI TATI ON	0	0	32, 0		32, 01	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	, -	0 0	(	
	OUTPATIENT SERVICE COST CENTERS		· · · ·				
90.00	09000 CLINIC	0	0		0 0	(	90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0	46, 32	20 0	46, 320	90.01
	09100 EMERGENCY	0	4, 725	385, 36		385, 364	
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS						_
	09500 AMBULANCE SERVICES	0	0	2, 93	35 0	2, 93	5 95.00
	SPECIAL PURPOSE COST CENTERS						110.00
	11300 INTEREST EXPENSE	70 004	11 (50	0 7EE 40	37 0	0 7EE 40	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	78, 984	11, 658	2, 755, 48	57 <u></u> 0	2, 755, 48	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	10, 18	31 0	10 19	1 190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0	145, 06			9 192.00
	07950 OCCUPATIONAL HEALTH	0	0	145,00	0 0		194.00
		0	0	23	-		194.00
194.00	07951 FOUNDATI ON	UI UI				200	
194. 00 194. 01	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0	o	1, 17	76 0	1, 176	5 194.03
194. 00 194. 01 194. 03		0	0 0	1, 17	76 0 0 0		5 194.03 0 194.04
194.00 194.01 194.03 194.04 200.00	07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN Cross Foot Adjustments	0 0	0 0	1, 17		(	0 194.04 0 200.00
194. 00 194. 01 194. 03 194. 04	07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN Cross Foot Adjustments Negative Cost Centers	0 0 0 78, 984	0 0 11, 658	1, 17 2, 912, 14	0 0 0 0 0 0	(	0 194.04 0 200.00 0 201.00

	Financial Systems LLOCATION - STATISTICAL BASIS	PARKVI EW LAGRA	NGE HOSPITAL Provider C	CN: 15-1323 P	In Lieu eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2022 o 12/31/2022	Date/Time Pre	
						5/26/2023 4:0	
			CAPITAL REI	_ATED COSTS			
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATION (SQUARE FEET)	(SQUARE FEET)	STATI ON EQUI P.	BENEFI TS DEPARTMENT	
			(SCOARE TEET)		(SQUARE FEET)	(GROSS	
		1.00	1 01	2.00	2.01	SALARI ES)	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	2.01	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	82, 172					1.00
1.01 2.00	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP	0	9, 760	82, 172			1.01
2.00	00201 EMS WEST STATION EQUIP.			02,172			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	-	12, 166, 517	
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	17, 939 4, 425		17, 939 4, 425		3, 525, 032 367, 981	
8.00	00800 LAUNDRY & LINEN SERVICE	253		253		0	1
9.00	00900 HOUSEKEEPI NG	828		828		332, 433	
	01000 DI ETARY 01100 CAFETERI A	3, 322		3, 322		161, 137 390, 390	
	01300 NURSI NG ADMI NI STRATI ON	0				437, 218	
	01400 CENTRAL SERVICES & SUPPLY	1, 578		1, 578		0	14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 358		1, 358		583, 887	
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	268	0	268	0	0	16.00
	03000 ADULTS & PEDI ATRI CS	17, 534				1, 567, 439	30.00
		264	0	264	0	165, 553	43.00
	ANCI LLARY SERVICE COST CENTERS	9, 994	0	9, 994	ol	810, 451	50.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 248				656, 073	
	05300 ANESTHESI OLOGY	0	-	0		0	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	4, 953 2, 130		4, 953 2, 130		934, 867 0	
	06500 RESPIRATORY THERAPY	598		598		337, 437	
	06600 PHYSI CAL THERAPY	1, 366		1, 366		204, 677	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 247		1, 247		186, 947 104, 817	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		04,017	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
	07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON	0702		0702	-	0 48, 424	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0		40, 424	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	910		0 910		0 193, 219	
	09001 LIFEBRIDGE SENIOR CARE	7, 001				1, 157, 682	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0.740	0	0.760	0	95.00
	SPECIAL PURPOSE COST CENTERS	0	9, 760	0	9, 760	0	95.00
	11300 INTEREST EXPENSE						113.00
118.00		78, 617	9, 760	78, 617	9, 760	12, 165, 664	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	ol	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332					192.00
	07950 OCCUPATI ONAL HEALTH	0	0	0			194.00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194.01 194.03
	07954 ER PHYSICIAN	0	0	0	0		194.03
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1 220 045	2 025	625, 492	0	5 100 E04	201.00
202.00	Part I)	1, 238, 865	2, 935	020, 492	0	5, 193, 534	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 076486	0. 300717	7. 611985	0. 000000	0. 426871	
204.00	Cost to be allocated (per Wkst. B,					0	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part					0.000000	205.00
	11)					2.000000	
206.00							206.00
	(per Wkst. B-2)						207.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00

	Financial Systems	PARKVI EW LAGRA		01 45 4000		u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre 5/26/2023 4:0	epared:
	Cost Center Description	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG	
		5A	5.00	7.00	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 1.01 2.00 2.01 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	-11, 217, 137 0 0 0 0 0 0 0 0	21, 550, 862 1, 457, 548 90, 078 563, 094 419, 612 543, 083 624, 333 35, 803	59, 808 253 828 3, 322 0 0	137, 525 0 0 0 0 0	58, 727 3, 322 0 1, 578	10.00 11.00 13.00
	01500 PHARMACY	0	934, 755		Ű	1, 358	1
	01600 MEDI CAL RECORDS & LI BRARY	0	6, 080			268	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0			46, 438	17, 534	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	266, 897	264	516	264	43.00
50.00	05000 OPERATING ROOM	0	2,073,306	9, 994	39, 052	9, 994	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 062, 268			1, 248	
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2,056,164		14, 803	4, 953	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	1, 336, 795 638, 229		0	2, 130 598	
66. 00	06600 PHYSI CAL THERAPY	0	305, 222		0	1, 366	
67.00	06700 OCCUPATI ONAL THERAPY	0	299, 200		0	1, 247	
68.00	06800 SPEECH PATHOLOGY	0	145, 380	699	0	699	68.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	185, 512		0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	248, 024		0	0	
	07697 CARDIAC REHABILITATION	0	956, 487 86, 536		0	702	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	00,000			0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0	0	90.00
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	0	354, 446		0	910 7, 001	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3, 433, 151	7,001	34, 672	7,001	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						/2.00
95.00	09500 AMBULANCE SERVI CES	17, 774	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS	1	1				
113.00 118.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)	-11, 199, 363	21, 371, 532	56, 253	137, 525	<b>FE 170</b>	113.00 118.00
110.00	NONREIMBURSABLE COST CENTERS	-11, 199, 303	21, 371, 332	50, 255	137, 525	55,172	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 874			223	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	79, 353		0		192.00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS		12, 193 60, 910		0		194.01 194.03
	07954 ER PHYSI CI AN		00, 910	0	0		194.03
200.00				l	Ŭ	0	200.00
201.00 202.00	Cost to be allocated (per Wkst. B,		11, 217, 137	2, 216, 196	146, 338	886, 864	201.00 202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 520496	37.055177	1.064083	15. 101470	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		407, 009	1, 172, 774	12, 402	45, 657	204.00
205.00	)		0. 018886	19. 608982	0. 090180	0. 777445	
206.00 207.00	(per Wkst. B-2)						206.00 207.00
207.00	Parts III and IV)						207.00

G           1.00         0           1.01         0           2.00         0           2.01         0           4.00         0           5.00         0           7.00         0           8.00         0           9.00         0           11.00         0           13.00         0           14.00         0           15.00         0           16.00         0	Cost Center Description Cost Center Description ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT 0101 EMS WEST STATION 0200 CAP REL COSTS-MVBLE EQUIP 0201 EMS WEST STATION EQUIP. 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	DI ETARY (MEALS SERVED) 10.00 8,883 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provi der CO CAFETERIA (FTE) 11.00 9,488 483 0 573 0		ri od: fom 01/01/2022 12/31/2022 CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00 1, 286, 871 41, 522	Worksheet B-1 Date/Time Pre 5/26/2023 4:0 PHARMACY (COSTED REQUIS.) 15.00 30,078	2 pm 2 pm 1.00 1.00 2.00 2.00 3.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
1.00       0         1.01       0         2.00       0         2.01       0         4.00       0         5.00       0         7.00       0         8.00       0         9.00       0         11.00       0         13.00       0         14.00       0         15.00       0         16.00       0	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT 0101 EMS WEST STATION 0200 CAP REL COSTS-MVBLE EQUIP 0201 EMS WEST STATION EQUIP. 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	(MEALS SERVED) 10. 00 8, 883 0 0 0 0 0 0 0 0 8, 883	(FTE) 11.00 9,488 483 0 573	ADMI NI STRATI 0 N (DI RECT NRSI NG HRS) 13.00 13.00 111, 312 0 0	SERVI CES & SUPPLY (COSTED REQUI S.) 14.00 14.00	PHARMACY (COSTED REQUIS.) 15.00	1. 00 1. 0 2. 00 2. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00
1.00       0         1.01       0         2.00       0         2.01       0         4.00       0         5.00       0         7.00       0         8.00       0         9.00       0         11.00       0         13.00       0         14.00       0         15.00       0         16.00       0	0100 CAP REL COSTS-BLDG & FIXT 0101 EMS WEST STATION 0200 CAP REL COSTS-MVBLE EQUIP 0201 EMS WEST STATION EQUIP. 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	8, 883 0 0 0 0 0 0 8, 883	9, 488 483 0 573	13.00 111,312 0 0	14.00		1.0 2.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0
1.00       0         1.01       0         2.00       0         2.01       0         4.00       0         5.00       0         9.00       0         11.00       0         13.00       0         14.00       0         15.00       0         16.00       0	0100 CAP REL COSTS-BLDG & FIXT 0101 EMS WEST STATION 0200 CAP REL COSTS-MVBLE EQUIP 0201 EMS WEST STATION EQUIP. 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	0 0 0 0 0 8, 883	483 0 573	0 0		30, 078	1.0 ⁻ 2.00 2.0 ⁻ 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	0101 EMS WEST STATION 0200 CAP REL COSTS-MVBLE EQUIP 0201 EMS WEST STATION EQUIP. 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	0 0 0 0 0 8, 883	483 0 573	0 0		30, 078	1.0 ⁰ 2.0 ⁰ 4.0 ⁰ 5.0 ⁰ 7.0 ⁰ 8.0 ⁰ 9.0 ⁰ 10.0 ⁰ 11.0 ⁰ 13.0 ⁰ 14.0 ⁰
15.00 0 16.00 0	1500 PHARMACY 1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	8, 883		0		30, 078	
16.00 0	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 4300 NURSERY	8, 883	0	0			1 10.00
	3000 ADULTS & PEDIATRICS 4300 NURSERY			0	0	0	
30.00 0	4300 NURSERY		0.011	10.00/			
43.00 0			2, 061 161	42, 986 3, 366	24, 288 29, 052	0	
	NCILLARI SERVICE COSI CENTERS	0	101	3, 300	27,002		
	5000 OPERATING ROOM	0	1, 012	21, 103	391, 959	0	
	5200 DELIVERY ROOM & LABOR ROOM	0	639	13, 338	115, 129	0	52.00
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0	0 1, 345	0	0 85, 574	0	
	6000 LABORATORY	0	1, 343	0	03, 374	0	
	6500 RESPI RATORY THERAPY	0	448	0	41, 034	0	65.00
	6600 PHYSI CAL THERAPY	0	528	0	2, 095	0	
	6700 OCCUPATIONAL THERAPY	0	228	0	1, 798	0	
	6800 SPEECH PATHOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	114 0	0	897 185, 678	0	68.0 71.0
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	248, 024	0	
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	30, 078	
	7697 CARDI AC REHABI LI TATI ON	0	94	0	761	0	
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.0
	9000 CLINIC	0	0	0	0	0	90.00
	9001 LI FEBRI DGE SENI OR CARE	0	338	0	1, 175	0	
	9100 EMERGENCY	0	1, 463	30, 519	115, 297	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	THER REI MBURSABLE COST CENTERS 9500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	PECIAL PURPOSE COST CENTERS	0	0	0	U		75.00
	1300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 883	9, 487	111, 312	1, 284, 283	30, 078	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	0	0	1 202	0	190.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	0	0	0	1, 283 837		190.00
	7950 OCCUPATI ONAL HEALTH	0	0	0	0		194.0
	7951 FOUNDATI ON	О	0	0	0		194.0
	7952 COMMUNITY & VOLUNTEER SVCS	0	1	0	468		194.0
194.040 200.00	7954 ER PHYSICIAN Cross Foot Adjustments	0	0	0	0		194. 0 200. 0
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B,	811, 282	825, 756	991, 332	136, 741	1, 546, 401	202.00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	91. 329731 151, 020	87. 031619 10, 257	8. 905886 12, 313	0. 106259 68, 649	51. 413026 78, 984	
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	17. 001013	1. 081050	0. 110617	0. 053346	2. 625972	205. 0
206.00	NAHE adjustment amount to be allocated						206.0
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.0

Heal th	Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL	In Lieu	of Form CMS-2552-10
	LLOCATION - STATISTICAL BASIS		Provi der CCN: 15-1323	Peri od:	Worksheet B-1
					Date/Time Prepared:
	Cost Center Description	MEDI CAL			5/26/2023 4:02 pm
		RECORDS &			
		LIBRARY (TIME SPENT)			
	[	16.00			
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.00
1.00	00101 EMS WEST STATION				1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
2.01 4.00	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT				2.01 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY				9.00 10.00
	01100 CAFETERI A				11.00
	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	10, 000			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 43.00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	2, 757 204			30.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	204	<u> </u>		43.00
	05000 OPERATING ROOM	306			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0			52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 2, 066			53.00 54.00
60.00	06000 LABORATORY	0			60.00
	06500 RESPI RATORY THERAPY	0			65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	481			66.00 67.00
68.00	06800 SPEECH PATHOLOGY	32			68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0			73.00 76.97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			77.00
00.00	OUTPATIENT SERVICE COST CENTERS	0	[		
	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0			90.00 90.01
	09100 EMERGENCY	4, 054			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
95.00	OTHER REIMBURSABLE COST CENTERS	0			95.00
,0,00	SPECIAL PURPOSE COST CENTERS	,			
	11300 INTEREST EXPENSE	10,000			113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	10,000			118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0			194.00 194.01
194.03	07952 COMMUNITY & VOLUNTEER SVCS	0			194.03
	07954 ER PHYSICIAN	0			194.04
200.00 201.00					200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	23, 223			202.00
202.02	Part I)	2 22220			
203.00 204.00		2. 322300 11, 658			203.00 204.00
204.00	Part II)	11, 000			204.00
205.00		1. 165800			205.00
206.00	NAHE adjustment amount to be allocated				206.00
	(per Wkst. B-2)				
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00
		I	1		I

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-		•			
30. 00 03000 ADULTS & PEDIATRICS	7, 287, 288		7, 287, 28	8 0	0	30.00
43.00 04300 NURSERY	467, 685		467,68		0	43.00
ANCILLARY SERVICE COST CENTERS	· · · · · ·					
50.00 05000 OPERATING ROOM	4,033,638		4, 033, 63	8 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 869, 074		1, 869, 07	4 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 531, 422		3, 531, 42	2 0	0	54.00
60. 00 06000 LABORATORY	2, 143, 685		2, 143, 68	5 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1,044,965				0	65.00
66. 00 06600 PHYSI CAL THERAPY	582, 628		582, 62		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	540, 238		540, 23		0	67.00
68.00 06800 SPEECH PATHOLOGY	267, 599	0	267, 59		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	301, 800		301, 80		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	403, 474		403, 47		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,000,736		3,000,73	6 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	176, 454		176, 45	4 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	·	•	•			
90. 00 09000 CLI NI C	0			0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	615, 938		615, 93	8 0	0	90.01
91.00 09100 EMERGENCY	6,042,926		6, 042, 92	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,036,158		2, 036, 15		0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES	0			0 0	0	95.00
SPECIAL PURPOSE COST CENTERS		I		-		
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	34, 345, 708	l o	34, 345, 70	8 0	0	200.00
201.00 Less Observation Beds	2,036,158		2, 036, 15			201.00
202.00 Total (see instructions)	32, 309, 550					202.00

Health Financial Systems	PARKVI EW LAGRAM	NGE HOSPI TAL		In Li	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022		
			XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other		
			+ col. 7)	Rati o	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 4 4 9 4 1					
30. 00 03000 ADULTS & PEDI ATRI CS	7, 164, 911		7, 164, 9			30.00
43.00 04300 NURSERY	804, 578		804, 5	/8		43.00
ANCI LLARY SERVICE COST CENTERS					-1	
50.00 05000 OPERATING ROOM	7, 282, 208	19, 080, 610				
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,000,003	188, 472				
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.00000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 380, 022	27, 340, 616				
60. 00 06000 LABORATORY	2, 468, 615	14, 423, 252				
65. 00 06500 RESPI RATORY THERAPY	1,014,489	5, 146, 671				
66. 00 06600 PHYSI CAL THERAPY	201, 254	1, 593, 477				
67.00 06700 OCCUPATI ONAL THERAPY	323, 632	424, 095	747,72	0. 72250		
68.00 06800 SPEECH PATHOLOGY	102, 499	146, 223	248, 72	1. 075890	6 0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	778, 010	1, 705, 343	2, 483, 3	53 0. 12152 ^o	9 0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	188, 186	1, 235, 444	1, 423, 6	30 0. 283412	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 890, 056	8, 129, 773	11, 019, 8	0. 27230	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	392, 914	392, 9 ⁻	14 0. 44909 ⁻	0. 000000	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0.00000	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0.00000	0. 000000	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	2, 451	847, 534	849, 9	0. 724640	0. 000000	90.01
91.00 09100 EMERGENCY	1, 120, 118	26, 240, 202	27, 360, 32	0. 22086	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	59, 041	1, 841, 296	1, 900, 3	37 1. 071472	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	· · ·		•			1
95.00 09500 AMBULANCE SERVICES	0	0		0 0.00000	0. 000000	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	28, 780, 073	108, 735, 922	137, 515, 9	95		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	28, 780, 073	108, 735, 922	137, 515, 9	95		202.00
				'		•

Health Financial Systems	PARKVI EW LAGRANG	E HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1323	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 4:0	
		Title XVIII	Hospi tal	Cost	
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 OPERATING ROOM	0. 000000				50.00
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
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
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
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. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 LI FEBRI DGE 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 SERVI CES	0. 000000				95.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
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	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-3	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 4:0	
	-		e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	7, 287, 288		7, 287, 28	8 0	7, 287, 288	30.00
43.00 04300 NURSERY	467, 685		467,68		467, 685	
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
50.00 05000 OPERATING ROOM	4,033,638		4, 033, 63	8 0	4, 033, 638	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 869, 074		1, 869, 07	4 0	1, 869, 074	52.00
53.00 05300 ANESTHESI OLOGY	0			0 0	0	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 531, 422		3, 531, 42	2 0	3, 531, 422	54.00
60. 00 06000 LABORATORY	2, 143, 685		2, 143, 68		2, 143, 685	60.00
65. 00 06500 RESPI RATORY THERAPY	1,044,965				1,044,965	
66. 00 06600 PHYSI CAL THERAPY	582, 628		582, 62		582, 628	66.00
67.00 06700 OCCUPATI ONAL THERAPY	540, 238		540, 23		540, 238	
68.00 06800 SPEECH PATHOLOGY	267, 599		267, 59		267, 599	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	301, 800		301, 80		301, 800	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	403, 474		403, 47		403, 474	
73.00 07300 DRUGS CHARGED TO PATIENTS	3,000,736		3,000,73	6 0	3,000,736	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	176, 454		176, 45	4 0	176, 454	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	·					1
90. 00 09000 CLI NI C	0			0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	615, 938		615, 93	8 0	615, 938	90.01
91.00 09100 EMERGENCY	6,042,926		6, 042, 92	6 0	6, 042, 926	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,036,158		2, 036, 15		2, 036, 158	
OTHER REIMBURSABLE COST CENTERS		-				1
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
SPECIAL PURPOSE COST CENTERS				· · ·		
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	34, 345, 708	0	34, 345, 70	8 0	34, 345, 708	
201.00 Less Observation Beds	2, 036, 158		2, 036, 15		2, 036, 158	
202.00 Total (see instructions)	32, 309, 550					
				-		

Health Financial Systems	PARKVI EW LAGRAM	NGE HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
			· · ·		Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	7, 164, 911		7, 164, 9	11		30.00
43.00 04300 NURSERY	804, 578		804, 5	78		43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	7, 282, 208	19, 080, 610	26, 362, 8	0. 153005	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 000, 003	188, 472	3, 188, 4	0. 586197	0. 000000	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 380, 022	27, 340, 616	28, 720, 6	0. 122958	0. 000000	54.00
60. 00 06000 LABORATORY	2, 468, 615	14, 423, 252	16, 891, 8	0. 126906	0. 000000	60.00
65.00 06500 RESPI RATORY THERAPY	1,014,489	5, 146, 671	6, 161, 10	0. 169605	0. 000000	65.00
66.00 06600 PHYSI CAL THERAPY	201, 254	1, 593, 477	1, 794, 73	0. 324632	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	323, 632	424, 095	747, 72	0. 722507	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	102, 499	146, 223	248, 72	1. 075896	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	778, 010	1, 705, 343	2, 483, 3	0. 121529	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	188, 186	1, 235, 444	1, 423, 63	0. 283412	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 890, 056	8, 129, 773	11, 019, 82	0. 272303	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	392, 914	392, 9	0. 449091	0. 000000	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0.000000	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0.000000	0.000000	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	2, 451	847, 534	849, 9	0. 724646	0. 000000	90.01
91.00 09100 EMERGENCY	1, 120, 118	26, 240, 202	27, 360, 32	0. 220865	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	59, 041	1, 841, 296	1, 900, 3	37 1. 071472	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1 1		1			
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0.000000	0.00000	95.00
SPECIAL PURPOSE COST CENTERS	1 1		1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	28, 780, 073	108, 735, 922	137, 515, 9	95		200.00
201.00 Less Observation Beds		100 705 555	107 515 5			201.00
202.00  Total (see instructions)	28, 780, 073	108, 735, 922	137, 515, 9	95		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1323         Period: To 01/01/2021         Worksheet C Date 1/1 me Prepared: 5/26/2031/2022           To Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         PPS           IMPATIENT ROUTINE SERVICE COST CENTERS         30.00         30.00         30.00         30.00           0.00 03000 ANDLTS & PEDIATRICS         30.00         30.00         30.00         30.00           A3.00 043000 NURSERY         0.153005         52.00         52.00         52.00           50.00 05000 DELIVERY MOOM & LABOR ROOM         0.586197         52.00         52.00         52.00           50.00 05000 Labors RAY MOOM & LABOR ROOM         0.122958         54.00         54.00         54.00           60.00 06000 LABORATORY         0.122958         54.00         66.00         66.00         66.00           66.00 06000 PHYSICAL THERAPY         0.122956         67.00         68.00         72.00         72.00           71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT         0.22303         73.00         73.00         73.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00         74.00	Health Financial Systems	PARKVI EW LAGRANG	E HOSPI TAL	In Lieu	u of Form CMS-	2552-10
Cost Center Description         PPS Inpatient Ratio         PPS Inpatient Ratio         Notestign         Notestign	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/26/2023 4:0	
Rait o         Rait o         11.00           30.00         03000         ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         43.00           ANCILLARY SERVICE COST CENTERS         50.00           50.00         05000         PERATING ROOM         0.153005           50.00         05000         PERATING ROOM         0.586197           51.00         05300         ANSTHESI OLOGY         0.000000           53.00         05400         RADIOLOGY-DI AGNOSTIC         0.122958           60.00         06000         LABORATORY         0.126906           60.00         06600         PERATINORY THERAPY         0.126906           61.00         06500         RESPI RADRY THERAPY         0.324632           66.00         06600         PERCH PATHOLOGY         1.075896           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0.121529           72.00         07200 IMPL, DEV. CHARGED TO PATIENTS         0.272303           73.00         07300 DRUGS CHARGED TO PATIENTS         0.272303           77.00         07700 ALLOGENEIC STEM CELL ACQUISITION         0.400001           77.00         07200 IMPL, DEV. CHARGED TO PATIENTS         0.272303           77.0			Title XIX	Hospi tal	PPS	
11.00         11.00         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           43.00         04300 NURSERY         43.00           ANCILLARY SERVICE COST CENTERS         50.00         05000 DELIVERY ROOM & LABOR ROOM         0.153005           50.00         05300 ANUSTRESI         0.000000         52.00           51.00         05300 ANESTHESI OLOGY         0.000000         53.00           52.00         05300 ANESTHESI OLOGY         0.000000         53.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.122958         64.00           60.00         06000 LABORATORY         0.126906         66.00           61.00         06600 PHYSI CAL THERAPY         0.1220507         66.00           66.00         06600 SEECH PATHOLOGY         1.075896         71.00           70.00         06700 CCUPATIONAL THERAPY         0.22432         72.00           70.00         07300 PUBLS CHARGED TO PATIENTS         0.283412         72.00           71.00         07300 DRUGS CHARGED TO PATIENTS         0.283412         73.00           70.00         0700 OLINES CHARGE TO PATIENTS         0.283412         73.00           70.00         0700 OLINE CHARGE TO TATIENT         0.283412         73.00 <td>Cost Center Description</td> <td>PPS Inpatient</td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description	PPS Inpatient				
INPATIENT ROUTINE SERVICE COST CENTERS         30.00           30.00         03000         AULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         50.00         50.00         50.00           50.00         05000         PERATING ROOM         0.153005         52.00           51.00         05000         PERATING ROOM         0.586197         52.00           53.00         05300         ANESTHESI 0LOGY         0.000000         53.00           60.00         06000         RAID IOGY DI AGNOSTI C         0.122958         54.00           60.00         06600         PERATORY THERAPY         0.324632         66.00           61.00         06600         PESPI RATORY THERAPY         0.324632         66.00           61.00         06600         PENDITI ONAL THERAPY         0.324632         67.00           61.00         06600         SPECH PATHOLOCY         1.075896         71.00           71.00         07100         IMEDI CAL SUPPLIES CHARGED TO PATIENT         0.212303         72.00           72.00         07200 IMPL. DEV. CHARGED TO PATIENTS         0.272303         73.00           73.00         07300 IDRUGS CHARGED TO PATIENTS         0.272303         73.00           77.00         <		Ratio				
30.00       03000 ADULTS & PEDIATRICS       30.00         43.00       04300 (MNSRERY       43.00         ANCILLARY SERVICE COST CENTERS       50.00       50.00       05000 (DEPRATING ROOM       0.153005       50.00         52.00       05300 (AUSTRESI OLOGY       0.000000       52.00       52.00       52.00         53.00       05300 (AUSTRESI OLOGY       0.000000       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       53.00       54.00       60.00       65.00       65.00       65.00       66.00       65.00       66.00       66.00       66.00       66.00       66.00       66.00       67.00       67.00       67.00       67.00       67.00       66.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       73.00       73.00       73.00       73.00       73.00       73.00       7		11.00				
43.00       04300       NURSERY       43.00         ANCI LLARY SERVICE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS					
ANCL LLARY SERVICE COST CENTERS         50.00         05000 DECATING ROOM         0.153005         50.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         54.00         54.00         54.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         65.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         72	30. 00 03000 ADULTS & PEDIATRICS					30.00
50.00       05000       0PERATING ROOM       0.153005       50.00         52.00       05200       DELIVERY ROM & LABOR ROOM       0.586197       52.00         53.00       05300       ANESTHESI OLOGY       0.000000       53.00         60.00       05400       RADI OLOGY-DI AGNOSTI C       0.122958       54.00         60.00       06000       LABORATORY       0.169605       65.00         60.00       06000       PHYSI RATORY THERAPY       0.169605       65.00         61.00       06600       PHYSI CAL THERAPY       0.324632       66.00         62.00       06000       CCUPATI ONAL THERAPY       0.725876       68.00         63.00       06000       SECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.272303       72.00         72.00       07200 I MPL.       DEV. CHARGED TO PATIENTS       0.272303       72.00         73.00       07300       RUES SCHARGED TO PATIENTS       0.272303       73.00         77.00       077020 ALLOGENEIC STEM CELL ACQUISITION       0.000000       70.01         77.00       00000 CLINIC       0.000000       90.00         70.00       07000 EMERGENCY	43.00 04300 NURSERY					43.00
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.586197       52.00         53.00       05300       ANESTHESI OLOGY       0.000000       53.00         64.00       05400       RADI DLOGY-DI AGNOSTI C       0.122958       60.00         60.00       06000       LABORATORY       0.126906       60.00         65.00       06500       RESPI RATORY THERAPY       0.126906       60.00         67.00       06700       0CCUPATI ONAL THERAPY       0.324632       66.00         68.00       06800       SPECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.283412       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.27303       73.00         77.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.0000000       77.00         90.00       09000       CLI NI C       0.0000000       90.01       90.01         91.00       9100       EMERGENCY       0.202065       91.01       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.071472	ANCILLARY SERVICE COST CENTERS					
53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.122958       54.00         60.00       0.6000       LABORATORY       0.126906       65.00         61.00       0.6000       LABORATORY       0.126906       65.00         62.00       0.6000       LABORATORY       0.126906       65.00         66.00       0.6000       LABORATORY       0.324632       66.00         67.00       06CUPATI ONAL THERAPY       0.324532       66.00         68.00       0.6800       SPEECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.121529       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.272303       73.00         73.00       07300       RUGS CHARGED TO PATI ENTS       0.272303       73.00         70.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       76.97         77.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       90.01         90.00       09000       CLI NI C       0.000000       90.01         90.00       09000 <t< td=""><td>50.00 05000 OPERATING ROOM</td><td>0. 153005</td><td></td><td></td><td></td><td>50.00</td></t<>	50.00 05000 OPERATING ROOM	0. 153005				50.00
54.00       05400       RADI 0LOGY-DI AGNOSTI C       0.122958       54.00         60.00       06000       LABORATORY       0.126906       60.00         65.00       06500       RESPI RATORY THERAPY       0.324632       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.324632       66.00         68.00       08600       SPEECH PATHOLOGY       1.075896       68.00         71.00       O7100       MEDI CAL SUPPLIES       CHARGED TO PATI ENT       0.121529         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.272303       73.00         76.97       CARDIA C REHABI LI TATI ON       0.49091       77.00         00       09000       CLINIC       0.000000       77.00         00.00       09000       CLINIC       0.2020865       90.00         90.00       09000       CLINIC CAST CENTERS       90.00       90.00         91.00       09000       LIFERIDES ENVICE COST CENTERS       90.00       90.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       1.071472       92.00         92.00       OSOCIAMEULANCE SERVICES <t< td=""><td>52.00 05200 DELIVERY ROOM &amp; LABOR ROOM</td><td>0. 586197</td><td></td><td></td><td></td><td>52.00</td></t<>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 586197				52.00
60.00       06000       LABORATORY       0.126906       60.00         65.00       06500       RESPIRATORY THERAPY       0.169605       65.00         66.00       0670       OCUPATIONAL THERAPY       0.324632       66.00         67.00       06700       OCUPATIONAL THERAPY       0.722507       67.00         68.00       96800       SPEECH PATHOLOGY       1.075896       68.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.121529       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.283412       72.00       73.00         74.00       OTOO (LINC CHERAGEN CO PATIENTS       0.272303       73.00       76.97         75.00       0700       ALIGENEI C STEM CELL ACQUISITION       0.000000       76.97         71.00       DUPATIENT SERVICE COST CENTERS       0.200000       90.00       90.00         90.00       09000       LIFBRIDGE SENI OR CARE       0.724646       90.01         91.00       09200       DESERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         92.00       OFHER REI MBURSABLE COST CENTERS       0.000000 <td< td=""><td>53.00 05300 ANESTHESI OLOGY</td><td>0. 000000</td><td></td><td></td><td></td><td>53.00</td></td<>	53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
65.00       06500       RESPI RATORY THERAPY       0.169605       65.00         66.00       06600       PHYSI CAL THERAPY       0.324632       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.722507       67.00         68.00       06800       SPEECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.121529       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.283412       72.00         73.00       D7300       DRUGS CHARGED TO PATI ENTS       0.272303       73.00         76.97       CARDI AC REHABI LI TATI ON       0.449091       76.97         77.00       O7000       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       77.00         00.00       O9000       CLI NI C       0.000000       90.01         90.00       09000       CLI FERI DGE SENI OR CARE       0.724646       90.01         91.00       D92000       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.071472       92.00         92.00       O92000       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.071472       92.00         92.00       O92000       OBSERVATI ON BEDS (NON-DI STI NCT PART       1.071472 <td>54.00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0. 122958</td> <td></td> <td></td> <td></td> <td>54.00</td>	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 122958				54.00
66.00       06600       PHYSI CAL THERAPY       0.324632       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.722507       67.00         68.00       06800       SPEECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.121529       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.283412       73.00         76.97       77700       ALDGENEIC STEM CELL ACQUISITION       0.449091       76.97         77.00       OTOOD ALLOGENEIC STEM CELL ACQUISITION       0.000000       90.00         90.00       09000       CLINIC       0.000000       90.01         91.00       09000       CLINIC       0.220865       90.01         92.00       OS200       OBSERVATION BEDS (NON-DISTINCT PART       0.220865       91.00         92.00       OS200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         92.00       OSSERVATION BEDS COST CENTERS       113.00       113.00       11300       11300       11300       11300       200.00         200.00       SPECIAL PURPOSE COS	60. 00 06000 LABORATORY	0. 126906				60.00
67.00       06700       0CCUPATIONAL THERAPY       0.722507       67.00         68.00       06800       SPEECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.121529       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.272303       73.00         76.97       07697       CARDIAC REHABILITATION       0.449091       76.97         77.00       OT700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       90.00         0UTPATIENT SERVICE COST CENTERS       0.202065       90.00       90.01         90.00       09000       CLINIC       0.000000       90.01         91.00       D9000       ELI REGENCY       0.2020865       91.00         92.00       OSERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         92.00       OSERVATION BEDS (COST CENTERS       0.000000       95.00         95.00       OSECIAL PURPOSE COST CENTERS       113.00       113.00         113.00       I1300       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00	65. 00 06500 RESPI RATORY THERAPY	0. 169605				65.00
68.00       06800       SPECH PATHOLOGY       1.075896       68.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.121529       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.272303       73.00         76.97       07697       CARDI AC REHABILITATION       0.449091       76.97         70.00       07700       ALLOGENEI C STEM CELL ACQUISITION       0.000000       77.00         01700       09001       LI FEBRI DGE SENI OR CARE       0.724646       90.01         90.00       09100       EMEGENCY       0.220865       91.00         92.00       09200       OBSERVATION BEDS (NON-DI STINCT PART       1.071472       92.00         95.00       09500       AMBULANCE SERVI CES       0.000000       92.00       92.00         95.00       09500       MBULANCE SERVI CES       0.000000       95.00       95.00         95.00       011300       INTREREST EXPENSE       113.00       11300       11300       11300         101.00       Less Observation Beds       200.00       201.00       201.00       201.00 <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0. 324632</td> <td></td> <td></td> <td></td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0. 324632				66.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.121529       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.272303       73.00         76.97       07697       CARDI AC REHABILI TATION       0.449091       76.97         77.00       07000 ALLOGENEIC STEM CELL ACQUISITION       0.000000       76.97         00000       CLINIC       0.000000       70.00         0010       09000       CLINIC       90.00         90.00       09000       CLINIC       90.00         91.00       O9100       EMERGENCY       0.220865         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART       1.071472         92.00       09500       AMBULANCE SERVICES       0.000000         95.00       SPECIAL PURPOSE COST CENTERS       95.00         95.00       SPECIAL PURPOSE COST CENTERS       95.00         113.00       INTEREST EXPENSE       0.000000         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 722507				67.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.283412       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.272303       73.00         76.97       07697       CARDI AC REHABILI TATION       0.449091       76.97         0700       ALLOGENEI C STEM CELL ACQUISITION       0.00000       77.00         00TPATIENT SERVICE COST CENTERS       0.00000       77.00         0000       09000       CLINIC       90.00         09000       DIFERSION CARE       0.724646       90.01         90.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         09200       OBSERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         09200       OBSERVATION SEDS (NON-DISTINCT PART       1.071472       95.00         09200       MBULANCE SERVICES       0.000000       95.00         SPECIAL PURPOSE COST CENTERS       113.00       11300       11300       113.00         113.00       Subtotal (see instructions)       200.00       201.00       201.00         201.00       Less Observation Beds       200.00       201.00       201.00	68.00 06800 SPEECH PATHOLOGY	1.075896				68.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0.272303       73.00         76.97       07697       CARDI AC REHABILITATION       0.449091       76.97         77.00       0700       ALLOGENEI C STEM CELL ACQUISITION       0.000000       77.00         0UTPATIENT SERVICE COST CENTERS       0.000000       00000       90.00       90.00         90.00       09000       CLINIC       0.000000       90.01         91.00       09010       EMERGENCY       0.220865       90.01         91.00       09200       OBSERVATION BEDS (NON-DI STINCT PART       1.071472       92.00         07HER       REIMBURSABLE COST CENTERS       0.000000       95.00         95.00       09200       AMBULANCE SERVICES       0.000000       95.00         95.01       113.00       INTEREST EXPENSE       0.000000       95.00         113.00       Less Observation Beds       113.00       200.00       201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 121529				71.00
76. 97       07697       CARDI AC REHABI LI TATI ON       0. 449091       76. 97         77. 00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0. 000000       77. 00         0UTPATI ENT SERVICE COST CENTERS       0. 000000       90. 00       90. 00         90. 00       09000       CLI NI C       0. 000000       90. 00         90. 01       09010 LI FEBRI DGE SENI OR CARE       0. 724646       90. 00         91. 00       09200       DBERVATI ON BEDS (NON-DI STI NCT PART       1. 071472       92. 00         07HER REI MBURSABLE COST CENTERS       0. 000000       95. 00       95.00       09500 AMBULANCE SERVI CES       0. 000000         95. 00       09500 AMBULANCE SERVI CES       0. 000000       95. 00       95. 00         95. 01       113.00       INTEREST EXPENSE       0. 000000       95. 00         91. 13.00       INTERST EXPENSE       0. 000000       200. 00         200. 00       Subtotal (see instructions)       200. 00       201. 00       201. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 283412				72.00
77.00       07700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       77.00         0UTPATI ENT SERVICE COST CENTERS       0.000000       90.00       90.00         90.00       09000       CLINIC       0.000000       90.00         90.01       09001       LIFEBRIDGE SENIOR CARE       0.724646       90.01         91.00       09100       EMERGENCY       0.220865       91.00         92.00       0SERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         0THER REI MBURSABLE COST CENTERS       0.000000       95.00         SPECIAL PURPOSE COST CENTERS       113.00       11300       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272303				73.00
OUTPATI ENT SERVICE COST CENTERS           90.00         09000 CLINIC         0.000000         90.00           90.01         09001 LI FEBRIDGE SENIOR CARE         0.724646         90.01           91.00         09100 EMERGENCY         0.220865         91.00           92.00         09SERVATION BEDS (NON-DISTINCT PART         1.071472         92.00           0THER REIMBURSABLE COST CENTERS         0.000000         95.00         95.00           95.00         09500 AMBULANCE SERVICES         0.000000         95.00           SPECIAL PURPOSE COST CENTERS         113.00         11300         11300           200.00         Subtotal (see instructions)         200.00         201.00           201.00         Less Observation Beds         201.00         201.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 449091				76.97
90.00       09000       CLINIC       0.00000       90.00         90.01       09001       LIFEBRIDGE SENIOR CARE       0.724646       90.01         91.00       09100       EMERGENCY       0.220865       91.00         92.00       09SERVATION BEDS (NON-DISTINCT PART       1.071472       92.00         0THER REIMBURSABLE COST CENTERS       0.000000       95.00       95.00         SPECIAL PURPOSE COST CENTERS       113.00       1NTEREST EXPENSE       113.00         113.00       Subtotal (see instructions)       200.00       201.00         201.00       Less Observation Beds       201.00       201.00	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000				77.00
90.01         09001         LI FEBRI DGE SENI OR CARE         0.724646         90.01           91.00         09100         EMERGENCY         0.220865         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART         1.071472         92.00           0THER         REI MBURSABLE COST CENTERS         0.000000         95.00           SPECI AL PURPOSE COST CENTERS         0.000000         113.00           113.00         INTERST EXPENSE         113.00           200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	OUTPATIENT SERVICE COST CENTERS					1
91.00         09100         EMERGENCY         0.220865         91.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00	90. 00 09000 CLINIC	0.000000				90.00
92.00         09200         0BSERVATION         BEDS (NON-DISTINCT PART         1.071472         92.00           0THER         REIMBURSABLE COST CENTERS         00.00000         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00 <td< td=""><td>90. 01 09001 LI FEBRI DGE SENI OR CARE</td><td>0. 724646</td><td></td><td></td><td></td><td>90.01</td></td<>	90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 724646				90.01
OTHER REI MBURSABLE COST CENTERS       95.00         95.00       O9500 AMBULANCE SERVICES       0.000000         SPECI AL PURPOSE COST CENTERS       113.00         113.00       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00	91.00 09100 EMERGENCY	0. 220865				91.00
OTHER REI MBURSABLE COST CENTERS       95.00         95.00       OP500 AMBULANCE SERVICES       0.000000         SPECI AL PURPOSE COST CENTERS       113.00         113.00       INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.071472				92.00
SPECIAL PURPOSE COST CENTERS         113.00       INTEREST EXPENSE         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00		· · · · · · · · · · · · · · · · · · ·				1
113.00         11300         INTEREST EXPENSE         113.00           200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00	95.00 09500 AMBULANCE SERVICES	0.000000				95.00
200.00         Subtotal (see instructions)         200.00         200.00         201.00         201.00	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				1
201.00 Less Observation Beds 201.00	113.00 11300 INTEREST EXPENSE					113.00
201.00 Less Observation Beds 201.00						
	202.00 Total (see instructions)					202.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Pre 5/26/2023 4:0	pared: 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
	(Wkst. B,	(Wkst. B,	Cost Net of		Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r					
50.00 05000 OPERATI NG ROOM	4, 033, 638				0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 869, 074	82, 311	1, 786, 76	03 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 531, 422	261, 946	3, 269, 47	6 0	0	54.00
60. 00 06000 LABORATORY	2, 143, 685	116, 997	2, 026, 68	8 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1,044,965	40, 486	1,004,47	'9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	582, 628	65, 848	516, 78	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	540, 238	59, 823	480, 41	5 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	267, 599	33, 063	234, 53	6 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	301, 800	13, 409	288, 39	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	403, 474	17, 915	385, 55	i9 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 000, 736	97, 048	2, 903, 68	8 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	176, 454	32, 017	144, 43	0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	615, 938	46, 320	569, 61	8 0	0	90.01
91.00 09100 EMERGENCY	6,042,926	385, 364	5, 657, 56	02 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,036,158	274, 761	1, 761, 39	07 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	2, 935	-2, 93	5 0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	26, 590, 735	2, 028, 103	24, 562, 63	2 0	0	200.00
201.00 Less Observation Beds	2, 036, 158	274, 761	1, 761, 39	07 0	0	201.00
202.00  Total (line 200 minus line 201)	24, 554, 577	1, 753, 342	22, 801, 23	0	0	202.00

Health Financial Systems	PARKVI EW LAGRA				u of Form CMS	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	GE RATIOS NET OF	Provider C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part II Date/Time Pr 5/26/2023 4:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,				
	Operati ng	Part I,	Charge Ratio	5		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6. 00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	4, 033, 638	26, 362, 818	0. 15300	05		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 869, 074	3, 188, 475				52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	00		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 531, 422	28, 720, 638	0. 12295	58		54.00
60. 00 06000 LABORATORY	2, 143, 685	16, 891, 867	0. 12690	06		60.00
65. 00 06500 RESPI RATORY THERAPY	1, 044, 965	6, 161, 160	0. 16960	05		65.00
66.00 06600 PHYSI CAL THERAPY	582, 628	1, 794, 731	0. 32463	32		66.00
67.00 06700 OCCUPATI ONAL THERAPY	540, 238	747, 727	0. 72250	)7		67.00
68.00 06800 SPEECH PATHOLOGY	267, 599	248, 722	1.07589	96		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Г 301, 800	2, 483, 353	0. 12152	29		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	403, 474	1, 423, 630	0. 2834	12		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 000, 736	11, 019, 829	0. 27230	03		73.00
76. 97 07697 CARDIAC REHABILITATION	176, 454	392, 914	0. 44909	91		76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	00		77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000	00		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	615, 938	849, 985	0. 72464	46		90.01
91.00 09100 EMERGENCY	6, 042, 926	27, 360, 320	0. 22086	55		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Г 2, 036, 158	1, 900, 337	1.07147	72		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0.0000	00		95.00
SPECIAL PURPOSE COST CENTERS			·			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	26, 590, 735	129, 546, 506				200.00
201.00 Less Observation Beds	2, 036, 158					201.00
202.00 Total (line 200 minus line 201)	24, 554, 577	129, 546, 506				202.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/26/2023 4:0	
			XVIII	Hospi tal	Cost	
Cost Center Description		Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	497, 860	26, 362, 818	0. 01888	5 334, 323	6, 314	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	82, 311	3, 188, 475			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	261, 946	28, 720, 638	0. 00912	0 130, 019	1, 186	54.00
60. 00 06000 LABORATORY	116, 997	16, 891, 867	0. 00692	6 276, 981	1, 918	60.00
65. 00 06500 RESPI RATORY THERAPY	40, 486	6, 161, 160	0. 00657	1 195, 100	1, 282	65.00
66.00 06600 PHYSI CAL THERAPY	65, 848	1, 794, 731	0. 03669	0 39, 195	1, 438	66.00
67.00 06700 OCCUPATI ONAL THERAPY	59, 823	747, 727	0. 08000	6 59, 096	4, 728	67.00
68.00 06800 SPEECH PATHOLOGY	33, 063	248, 722	0. 13293	2 30, 666	4, 076	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 409	2, 483, 353	0. 00540	64, 402	348	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 915	1, 423, 630	0. 01258	66, 658	839	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	97, 048	11, 019, 829	0. 00880	395, 690	3, 485	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	32, 017	392, 914	0. 08148	6 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	46, 320	849, 985	0. 05449	5 975	53	90.01
91.00 09100 EMERGENCY	385, 364	27, 360, 320	0. 01408	5 385	5	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	274, 761	1, 900, 337	0. 14458	5 9, 752	1, 410	92.00
OTHER REIMBURSABLE COST CENTERS			•			
95.00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	2, 025, 168	129, 546, 506		1, 603, 242	27, 082	200.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022		pared: 2 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
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		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-			-	-	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	1			,		

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2022 To 12/31/2022			
		Title	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.	to Charges		
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷		
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)		
			and 4)		(see		
					instructions)		
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0		0 26, 362, 818	0.000000	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 188, 475	0.000000	52.00	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	53.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 28, 720, 638	0.000000	54.00	
60.00 06000 LABORATORY	0	0		0 16, 891, 867	0.000000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 161, 160	0.000000	65.00	
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 794, 731	0.000000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 747, 727	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 248, 722	0.000000	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 483, 353	0.000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 423, 630	0.000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 019, 829		73.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 392, 914	0.000000	76.97	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 849, 985	0.000000	90.01	
91. 00 09100 EMERGENCY	0	0		0 27, 360, 320	0.000000	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 900, 337		92.00	
OTHER REIMBURSABLE COST CENTERS						1	
95. 00 09500 AMBULANCE SERVICES						95.00	
200.00 Total (lines 50 through 199)	0	0		0 129, 546, 506		200.00	
		•	•			•	

Health Financial Systems	PARKVI EW LAGRAN	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	
		Title	XVIII	Hospi tal	Cost	
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	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 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	334, 323		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	130, 019		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	276, 981		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	195, 100		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	39, 195		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	59, 096		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	30, 666		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	64, 402		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	66, 658		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	395, 690		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000	975		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	385		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	9, 752		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	· ·		•			1
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		1, 603, 242		0 0	0	200.00
			•			

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCIN		Provider C		Period: From 01/01/2022 To 12/31/2022		pared:
					5/26/2023 4:0	
		Title	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0. 153005		1, 962, 72	.7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 586197	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122958	0	4, 373, 38	34 0	0	54.00
60. 00 06000 LABORATORY	0. 126906	0	2, 318, 87	4 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 169605	0	1, 129, 51	1 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 324632	0	346, 91	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 722507	0	94, 43	2 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.075896	0	37, 69	02 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 121529	0	144, 59	09 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 283412	0	248, 41	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272303	0	2, 950, 51	0 3, 198	0	73.00
76. 97 07697 CARDI AC REHABILI TATI ON	0. 449091	l o	132, 60	01 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	l o		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			•	- <b>I</b>		1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 724646	0	489, 78	34 0	0	90.01
91.00 09100 EMERGENCY	0. 220865		4, 013, 44		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.071472					92.00
OTHER REIMBURSABLE COST CENTERS		-		-1 -	-	
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
200.00 Subtotal (see instructions)	0100000	0	18, 562, 22	7,138	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ		0 0	Ű	201.00
Only Charges				- -		
202.00 Net Charges (line 200 - line 201)		0	18, 562, 22	7, 138	0	202.00

ealth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	PARKVI EW LAGRAI	Provi der C	CN: 15-1323	Period:	u of Form CMS-2552- Worksheet D
TORTONWENT OF WEDTCAE, OTHER HEALTH SERVICES AN	D VACCINE COST	TTOVIDEI C	GN: 15-1525	From 01/01/2022	Part V
				To 12/31/2022	Date/Time Prepare
			XVIII	llooni tol	5/26/2023 4:02 pm Cost
	Cos			Hospi tal	LOSI
Cost Center Description	Cost	Cost	-		
cost center bescription	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00			
ANCI LLARY SERVI CE COST CENTERS					
D. 00 05000 OPERATING ROOM	300, 307	0			50.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.
3. 00 05300 ANESTHESI OLOGY	0	0			53.
I. 00 05400 RADI OLOGY-DI AGNOSTI C	537, 743	0			54.
0. 00 06000 LABORATORY	294, 279	0			60.
5. 00 06500 RESPIRATORY THERAPY	191, 571	0			65.
5. 00 06600 PHYSI CAL THERAPY	112, 618	0			66.
7. 00 06700 OCCUPATI ONAL THERAPY	68, 228	0			67.
3. 00 06800 SPEECH PATHOLOGY	40, 553	0			68.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 573	0			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	70, 404	0			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	803, 433	871			73.
5. 97 07697 CARDI AC REHABI LI TATI ON	59, 550	0			76.
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC	0	0			90.
D. 01 09001 LI FEBRI DGE SENI OR CARE	354, 920	0			90.
1.00 09100 EMERGENCY	886, 430	870			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	342, 160	0	1		92.
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES	0				95.
00.00 Subtotal (see instructions)	4, 079, 769	1, 741			200.
1.00 Less PBP Clinic Lab. Services-Program	0				201.
Only Charges					
02.00 Net Charges (line 200 - line 201)	4, 079, 769	1, 741			202.

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-1323	Period: From 01/01/2022	Worksheet D Part I		
				To 12/31/2022			
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost	t	col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col. 2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	983, 351	120, 822	862, 52	3, 315	260. 19	30.00	
43.00 NURSERY	18, 794		18, 79	389	48.31	43.00	
200.00 Total (lines 30 through 199)	1, 002, 145		881, 32	3, 704		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 & PEDIATRICS	65	16, 912				30.00	
43.00 NURSERY	13	628				43.00	
200.00 Total (lines 30 through 199)	78	17, 540				200.00	

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	5/26/2023 4:0	pared: 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	497, 860	26, 362, 818	0. 01888	5 143, 882	2, 717	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	82, 311	3, 188, 475	0. 02581	5 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	261, 946	28, 720, 638	0. 00912	20, 098	183	54.00
60. 00 06000 LABORATORY	116, 997	16, 891, 867	0. 00692	6 54, 980	381	60.00
65. 00 06500 RESPI RATORY THERAPY	40, 486	6, 161, 160	0. 00657	39, 714	261	65.00
66.00 06600 PHYSI CAL THERAPY	65, 848	1, 794, 731	0. 03669	0 3, 985	146	66.00
67.00 06700 OCCUPATI ONAL THERAPY	59, 823	747, 727	0. 08000	6 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	33, 063	248, 722	0. 13293	2 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 409	2, 483, 353	0. 00540	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 915	1, 423, 630	0. 01258	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	97,048	11, 019, 829	0. 00880	53, 294	469	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	32,017	392, 914	0. 08148	6 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	46, 320	849, 985	0. 05449	5 0	0	90.01
91.00 09100 EMERGENCY	385, 364		0.01408	5 22,600	318	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	274, 761				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 025, 168	129, 546, 506		338, 553	4, 475	200.00

Health Financial Systems	PARKVI EW LAGRA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	IER PASS THROUGH COS	TS Provider C		Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	C	30.00
43. 00 04300 NURSERY	0	0		0 0	C	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	C	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
•	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	5 5	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	3, 31	5 0.00	65	30.00
43.00 04300 NURSERY		0	38	9 0.00	13	43.00
200.00 Total (lines 30 through 199)		0	3, 70	4	78	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	pared: 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 (	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0 0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0 0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
OUTPATI ENT SERVI CE COST CENTERS	-			-	-	
90. 00 09000 CLINIC	0	0		0 (	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART	0	-		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-			-	-	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	-					

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2022 To 12/31/2022			
		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.	to Charges		
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷		
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)		
			and 4)		(see		
					instructions)		
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0		0 26, 362, 818	0.00000	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 188, 475	0.00000	52.00	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	53.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 28, 720, 638	0. 000000	54.00	
60. 00 06000 LABORATORY	0	0		0 16, 891, 867	0.00000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 161, 160	0.00000	65.00	
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 794, 731	0.00000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 747, 727	0.000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 248, 722	0.000000	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 483, 353	0.000000	71.00	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 423, 630		72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 019, 829	0.000000	73.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 392, 914		76.97	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00	
OUTPATIENT SERVICE COST CENTERS				- <b>I</b>			
90. 00 09000 CLINIC	0	0		0 0	0.00000	90.00	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 849, 985	0.000000	90.01	
91.00 09100 EMERGENCY	0	0		0 27, 360, 320		91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 900, 337		92.00	
OTHER REIMBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,			
95. 00 09500 AMBULANCE SERVICES						95.00	
200.00 Total (lines 50 through 199)	0	0		0 129, 546, 506		200.00	

Health Financial Systems	PARKVI EW LAGRAN	GE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2022 To 12/31/2022	5/26/2023 4:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 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	143, 882		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	20, 098		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	54, 980		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	39, 714		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 985		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	53, 294		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	22, 600		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		338, 553		0 0	0	200.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1323	Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		•				
50.00 05000 OPERATING ROOM	0. 153005	0		0 53, 532	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 586197	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 122958	0		0 212, 916	0	54.00
60. 00 06000 LABORATORY	0. 126906	0		0 135, 922	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 169605	0		0 27, 365	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 324632	0		0 9, 833	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 722507	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.075896	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 121529	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 283412	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272303	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 449091	0		0 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 724646	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 220865	0		0 333, 391	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.071472	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
200.00 Subtotal (see instructions)		0		0 772, 959	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 772, 959	0	202.00

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider CO		Peri od: From 01/01/2022 To 12/31/2022	5/26/2023 4:	epared: 02 pm
		Ti tl	e XIX	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	1	0.101				
50. 00 05000 OPERATI NG ROOM	0	8, 191				50.00
52.00 05200 DELIVERY 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	26, 180				54.00
60. 00 06000 LABORATORY	0	17, 249				60.00
65. 00 06500 RESPI RATORY THERAPY	0	4, 641				65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 192				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
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. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	-				90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0				90.01
91.00 09100 EMERGENCY	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	133, 087				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	133, 087				202.00

	Financial Systems         PARKVIEW LAGRANG           ATION OF INPATIENT OPERATING COST         PARKVIEW LAGRANG	Provider CCN: 15-1323	Period: From 01/01/2022	u of Form CMS-2 Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/26/2023 4:03	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS			2,022	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 822 3, 315	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	aveb boo		2, 259	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	458	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	49	7
00	reporting period	m dava) aftar Daaambar	21 of the post	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	uays) after becember	31 OF the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	465	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	205	10
. 00	through December 31 of the cost reporting period (see instruc	ctions)	5 .	200	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period	<u> </u>	5 .		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar v			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost		17
00	reporting period				10
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	250.44	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of	the cost	250.44	20
. 00	reporting period			230.44	
	Total general inpatient routine service cost (see instruction			7, 287, 288	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 21 of the cost report	ing pariod (line	12, 272	2
. 00	7 x line 19)	er of the cost report	rng period (rine	12,272	
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			895, 378	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 391, 910	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation hed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		nar ges)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00 0	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	6, 391, 910	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 928. 18	38
			1		
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		896, 604 0	39 40

	Financial Systems TATION OF INPATIENT OPERATING COST	PARKVI EW LAGRAN		CN: 15-1323	Peri od:	u of Form CMS-: Worksheet D-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	nare
						5/26/2023 4:0	
	Cost Center Description	Total	Title Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpatient	Inpatient	Diem (col.		(col. 3 x	
		Cost	Days	÷ col . 2)		col. 4)	
2 00		1.00	2.00	3.00	4.00	5.00	42
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.0	0 0	0	42.
3.00	I NTENSI VE CARE UNI T						43.
4.00	CORONARY CARE UNIT						44.
5.00	BURN INTENSIVE CARE UNIT						45.
5.00 7.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
. 00	Cost Center Description						
						1.00	10
3.00 3.01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	369, 503 0	
9.00	Total Program inpatient costs (sum of lines					1, 266, 107	
	PASS THROUGH COST ADJUSTMENTS	5	/ ~	,		· · ·	
0. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.
1.00	) Pass through costs applicable to Program inp	ationt ancillar	v services (f	rom Wkst D	sum of Parts II	0	51.
. 00	and IV)		y services (i	TOIL WKST. D,	3011 01 101 13 11	0	51.
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.
3.00	Total Program inpatient operating cost exclu	0 1	lated, non-ph	ysician anest	hetist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program di scharges					0	54.
. 00	Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	
. 02 . 00	Adjustment amount per discharge (contractor					0. 00 0	
. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		rget amount (	line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing obser and ra	get amount (			0	
. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	endi ng 1996,	0.00	59.
00	updated and compounded by the market basket)			aget report	undeted by the	0.00	1 40
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or time 55 tro	in prior year	cost report,	updated by the	0.00	60.
. 00	Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target a	mount (line 5	6), otherwise		
2.00	Relief payment (see instructions)					0	62.
3.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to the second Data			ing and (Coo	205 277	
. 00	instructions)(title XVIII only)	ts through bece		le cost report	ring period (See	395, 277	04.
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only); for	395, 277	66.
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.
	(line 12 x line 19)				-p-: :::g p-::	-	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69.
. 00	PART III - SKILLED NURSING FACILITY, OTHER N			,		0	1 0 /.
. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	)		70.
. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x l	ine 35)			72.
. 00	Total Program general inpatient routine serv						74.
. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.
. 00	26, line 45)	no 2)					74
00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces						79
00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81
. 00	Reasonable inpatient routine service cost (		•				83
. 00	Program inpatient ancillary services (see in	structi ons)					84
. 00	Utilization review - physician compensation						85.
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86.
00	Total observation bed days (see instructions					1, 056	87.
. 00							

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	pared: 2 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			2, 036, 158	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	983, 351	7, 287, 288	0. 13494	2, 036, 158	274, 761	90.00
91.00 Nursing Program cost	0	7, 287, 288	0.00000	2, 036, 158	0	91.00
92.00 Allied health cost	0	7, 287, 288	0.0000	2, 036, 158	0	92.00
93.00 All other Medical Education	0	7, 287, 288	0.0000	2, 036, 158	0	93.00

	Financial Systems PARKVIEW LAGRANGE ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1323	Period: From 01/01/2022	u of Form CMS-2 Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/26/2023 4:02	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		3, 822	1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs	3, 315 0	2
00	do not complete this line.	ijo). Ti jou nave om j p	rivere room days,	0	
00	Semi-private room days (excluding swing-bed and observation b			2, 259	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	458	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	49	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December :	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excluding	g swing-bed and	65	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00			te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			389	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			13	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		17
	reporting period	C C			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	250. 44	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	250.44	20
	reporting period				
	Total general inpatient routine service cost (see instruction			7, 287, 288	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	er 31 of the cost repor	ting period (iine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	a 21 of the east report	ing pariod (line	12, 272	2
. 00	7 x line 19)	a si ui the cust repuit	ing period (inte	12, 272	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			895, 378	24
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 391, 910	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cl	harges)	0	28
	Semi -private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	31
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li		,	0.00	35
	Private room cost differential adjustment (line 3 x line 35)	and private seem east -	fforontial (1)-	0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	inerential (IINe	6, 391, 910	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		I	1 020 10	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 928. 18 125, 332	
0.00		/		0,002	
	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40

	ATION OF INPATIENT OPERATING COST		NGE HOSPITAL Provider C		Period:	Worksheet D-1	2552-
					rom 01/01/2022 o 12/31/2022		
				e XIX	Hospi tal	5/26/2023 4:0 PPS	)2 pm
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4.00	<u>col.4)</u> 5.00	
2.00	NURSERY (title V & XIX only)	467, 685	389				42.0
2 00	Intensive Care Type Inpatient Hospital Units						1 42 0
3.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						43.C
5.00	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	cost center bescription					1.00	
8.00	Program inpatient ancillary service cost (Wk					58, 997	
8.01 9.00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 199, 959	
9.00	PASS THROUGH COST ADJUSTMENTS	41 through 48.0				177, 737	49.0
0.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	17, 540	50.0
1 00	)	ationt andillar	n convioco (fi	com Wkot D o	um of Dorto II	4 475	E1 (
1.00	Pass through costs applicable to Program inp and IV)	attent and that	y services (II	OM WKSL. D, S	um of Parts II	4, 475	51.0
2.00	Total Program excludable cost (sum of lines	50 and 51)				22, 015	52.0
3.00	Total Program inpatient operating cost exclu	5 1	elated, non-phy	ysician anesth	etist, and	177, 944	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4.00	Program di scharges					0	54.0
5.00	Target amount per discharge					0.00	
5.01 5.02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor					0.00 0.00	
5.02	Target amount (line 54 x sum of lines 55, 55		)			0.00	
7.00	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	
3.00	Bonus payment (see instructions)					0	
9.00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		n the cost repo	orting period	ending 1996,	0.00	59.
0.00	Expected costs (lesser of line 53 ÷ line 54,		om prior year o	cost report, u	pdated by the	0.00	60.
1. 00	market basket) Continuous improvement bonus payment (if lin					0	61.
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
2.00	Relief payment (see instructions)					0	62.
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	uctions)			0	63.0
4.00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the o	cost reporting	period (See	0	65.
6.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line (	55)(title XVII	lonlv): for	0	66.
	CAH, see instructions		·	, ,	5.	-	
7.00	Title V or XIX swing-bed NF inpatient routin	ne costs through	n December 31 (	of the cost re	porting period	0	67.
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after [	December 31 of	the cost repo	rting period	0	68.
	(line 13 x line 20)		(I) ( <b>-</b> I)	( 2 )			
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N			,		0	69.0
0. 00	Skilled nursing facility/other nursing facil						70.
1.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 x li	ne 35)			72. 73.
4.00	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient	routine service	e costs (from )	Worksheet B, P	art II, column		75.
5.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76.
7.00	Program capital -related costs (line 9 x line						77.
. 00	Inpatient routine service cost (line 74 minu	us line 77)					78.
. 00	Aggregate charges to beneficiaries for exces						79.
. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi			i (iine /ơ mìn	us IIIle /9)		80.
. 00	Inpatient routine service cost per dicimination (I		1)				82.
. 00	Reasonable inpatient routine service costs (	•	ıs)				83.
4.00 5.00	Program inpatient ancillary services (see in Utilization review - physician compensation		ans)				84. 85.
5.00	Total Program inpatient operating costs (sum						85.
	PART IV - COMPUTATION OF OBSERVATION BED PAS		5 /				
7.00	Total observation bed days (see instructions					1,056	

Health Financial Systems	PARKVI EW LAGRA	NGE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 15-1323	Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 4:0	pared: 2 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)	)			2, 036, 158	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	983, 351	7, 287, 288	0. 13494	2, 036, 158	274, 761	90.00
91.00 Nursing Program cost	0	7, 287, 288	0.0000	2, 036, 158	0	91.00
92.00 Allied health cost	0	7, 287, 288	0.0000	2, 036, 158	0	92.00
93.00 All other Medical Education	0	7, 287, 288	0.0000	2, 036, 158	0	93.00

Health Financial Systems	PARKVI EW LAGRANGE HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1323	Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	narod
			10 12/31/2022	5/26/2023 4:0	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	<u>col. 2)</u>	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			004.040		
30. 00 03000 ADULTS & PEDIATRICS			984, 960		30.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 15300	334, 323	51, 153	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 58619		51, 155	52.00
53. 00 05300 DEETVERT ROOM & EABOR ROOM		0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12295		15, 987	
60. 00 06000 LABORATORY		0. 12690		35, 151	
65. 00 06500 RESPIRATORY THERAPY		0. 16960		33, 090	
66. 00 06600 PHYSI CAL THERAPY		0. 32463		12, 724	•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 72250		42, 697	
68.00 06800 SPEECH PATHOLOGY		1.07589		32, 993	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12152	64, 402	7, 827	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2834	12 66, 658	18, 892	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27230	395, 690	107, 748	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4490	91 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000		0	
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 72464		707	
91.00 09100 EMERGENCY		0. 2208		85	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.0714	72 9, 752	10, 449	92.00
95. 00 09500 AMBULANCE SERVICES			1 (02 242	2/0 502	95.00
200.00Total (sum of lines 50 through 94 and201.00Less PBP Clinic Laboratory Services-Pr			1, 603, 242	369, 503	200.00
201.00 Less PBP Clinic Laboratory Services-Pr 202.00 Net charges (line 200 minus line 201)	ogram onry charges (Trhe 61)		1 602 242		201.00
202.00   INEL CHALGES (TTHE 200 III HUS TTHE 201)		I	1, 603, 242		202.00

Health Financial Systems	PARKVIEW LAGRANGE HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1323	Peri od:	Worksheet D-3	
	Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	narod
	Component	CCN. 15-Z323	10 12/31/2022	5/26/2023 4:0	
	Title	XVIII	wing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDIATRICS					30.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 15300	5 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 58619		0	52.00
53. 00 05300 DEETVERT ROOM & EABOR ROOM		0.00000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12295		2, 314	54.00
60. 00 06000 LABORATORY		0. 12273		4, 284	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 16960		2, 927	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 32463		13, 556	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 72250		55, 159	
68. 00 06800 SPEECH PATHOLOGY		1. 07589		23, 313	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 12152		786	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 28341	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27230	3 30, 733	8, 369	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 44909	1 0	0	76.97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 00000		0	
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 72464		57	90.01
91.00 09100 EMERGENCY		0. 22086		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.07147	2 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			-		05 00
95. 00 09500 AMBULANCE SERVICES			244 004	110 7/5	95.00
200.00 Total (sum of lines 50 through 94 and			246, 884	110, 765	
201.00Less PBP Clinic Laboratory Services-Pr202.00Net charges (line 200 minus line 201)	ogram only charges (TThe 61)		244 004		201.00
202.00 [Net charges (The 200 minus The 201)		I	246, 884		202.00

Health Financial Systems PARKVIEW LAGRAN	GE HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1323	Peri od:	Worksheet D-3	
			From 01/01/2022	Data /Tima Dra	norod.
			To 12/31/2022	Date/Time Pre 5/26/2023 4:0	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			045.447		
30. 00 03000 ADULTS & PEDI ATRI CS			315, 417		30.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS			0		43.00
50. 00 05000 OPERATING ROOM		0. 1530	05 143, 882	22, 015	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5861		22,015	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1229			
60. 00 06000 LABORATORY		0. 1269			
65. 00 06500 RESPIRATORY THERAPY		0. 1696		6, 736	•
66. 00 06600 PHYSI CAL THERAPY		0. 3246		1, 294	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 7225		0	
68. 00 06800 SPEECH PATHOLOGY		1.0758	96 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1215	29 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2834	12 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2723	53, 294	14, 512	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4490		0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000		0	
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 7246		0	
91.00 09100 EMERGENCY		0. 2208		4, 992	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.0714	72 0	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES		1			95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			338, 553	58, 997	
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		550, 555	50, 997	200.00
202.00 Net charges (line 200 minus line 201)			338, 553		201.00
202. 00 million file cliques (The 200 millios The 201)		I	1 330, 333	l	202.00

	Financial Systems PARKVIEW LAGRANGE			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2023 4:0 Cost	2 piii
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	+:)		4, 081, 510	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	tions)		0	
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	IV and 12 line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTHE 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 081, 510	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basi s	0	15.00
16.00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete on	lyifline 18 exceeds l	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete on	lvifline 11 exceeds li	ne 18) (see	0	20.00
20100	instructions)		10 10) (000	-	
21.00 22.00	Lesser of cost or charges (see instructions)			4, 122, 325 0	1
22.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	·		0	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	<u></u>		53, 450	25.00
26.00	Deductibles and Coinsurance amounts (for CAR, see fistraction Deductibles and Coinsurance amounts relating to amount on lin		ructions)	3, 235, 222	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	833, 653	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			833, 653 147	
	Subtotal (line 30 minus line 31)			833, 506	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0 316, 162	
35.00	Adjusted reimbursable bad debts (see instructions)			205, 505	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		181,777	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 039, 011 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50 39.75	Pioneer ACO demonstration payment adjustment (see instruction N95 respirator payment adjustment amount (see instructions)	is)		0	39.50 39.75
39.97	Demonstration payment adjustment amount (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 039, 011	
40.00	Sequestration adjustment (see instructions)			13, 092	
40.02	Demonstration payment adjustment amount after sequestration			0	
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			1, 216, 710	40.03
	Interim payments-PARHM or CHART			172107710	41.01
42.00	Tentative settlement (for contractors use only)			0	
42.01 43.00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			-190, 791	42.01 43.00
43.00	Balance due provider/program-PARHM (see instructions)			1,0,7,1	43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0.00	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	PARKVI EW LAGRANGE HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Period: From 01/01/2022	Worksheet E		
			Date/Time Pre	
			5/26/2023 4:0	2 pm
	Title XVIII	Hospi tal	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F		Period: From 01/01/2022 To 12/31/2022		pared:
		Title	XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		863, 42	27 0	1, 027, 410 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/11/2022	67, 90	00 08/11/2022	189, 300	3.01
3.02				0	0	3.02
3. 03 3. 04				0	0	3.0
3.04				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51 3. 52				0	0	3.5 3.5
3.52 3.53				0	0	3.5
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		67, 90	00	189, 300	3.99
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 appropriate)		931, 32	27	1, 216, 710	4.00
	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)					5.00
	Program to Provider				-	
5.01 5.02	TENTATI VE TO PROVIDER			0	0	5.01 5.02
5.02 5.03				0	0	5.02
0.00	Provider to Program		<u>.</u>			0.00
5.50	TENTATIVE TO PROGRAM			0	0	5.50
5.51				0	0	5.5
5.52 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.5 5.9
5. 77	5. 50-5. 98)			0	0	5.7
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01	SETTLEMENT TO PROVIDER		187, 46	65	0	6.0
5.02	SETTLEMENT TO PROGRAM		4 440 7	0	190, 791	6.0
7.00	Total Medicare program liability (see instructions)		1, 118, 79	2 Contractor	1,025,919 NPR Date	7.0
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC		Period:	Worksheet E-1	
		Component (		From 01/01/2022 Fo 12/31/2022		pared:
					5/26/2023 4:0	2 pm
		litle Inpatien		wing Beds - SNF	Cost	
		inpatien	LPAILA	Par	ιв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		432, 210	5	0	1.00
2.00	Interim payments payable on individual bills, either		(	D	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					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)					
2 01	Program to Provider	00 /11 /2022	40.40			
3.01 3.02	ADJUSTMENTS TO PROVIDER	08/11/2022	40, 100 (		0	3.0 ² 3.02
3.02					0	3.02
3.04					0	3.04
3.05			(		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			ס	0	3.50
3.51				D	0	3.5
3.52 3.53					0	3.52 3.52
3.53					0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		40, 100		0	3.99
0. , ,	3. 50-3. 98)		107 100			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		472, 310	5	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER				0	5.0
5.02 5.03					0	5.02 5.02
J. US	Provider to Program				0	5.0
5.50	TENTATI VE TO PROGRAM		(		0	5.50
5.51				D	0	5.5
5. 52				ס	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(	D	0	5.99
6.00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		29, 850	b	0	6.0
6. 02	SETTLEMENT TO PROGRAM		(	D	0	6.02
7.00	Total Medicare program liability (see instructions)		502, 166		0	7.00
				Contractor	NPR Date	
		C	)	Number 1.00	(Mo/Day/Yr) 2.00	
	Name of Contractor	(	)	1.00	2.00	8.00

Heal th	Financial Systems PARKVIEW LAGRAN	GE HOSPI TAL	In Lie	u of Form CMS	-2552-10				
CALCU	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1323 Period: W From 01/01/2022 P								
			To 12/31/2022		epared				
	5/26/2023								
		Title XVIII	Hospi tal	Cost					
				1.00					
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION								
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	t. S-3, Pt. I col. 15 lin	e 14		1.00 2.00				
	2.00 Medicare days (see instructions)								
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00				
4.00	Total inpatient days (see instructions)				4.00				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	11			5.00				
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00				
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified Hil technology	WKST. S-2, PT. I		7.00				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00				
9.00	Sequestration adjustment amount (see instructions)				9.00				
10.00	00 Calculation of the HIT incentive payment after sequestration (see instructions)								
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH								
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00				
31.00	Other Adjustment (specify)				31.00				
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00				

2.00       Impletient routine services - swing bed-MF (see instructions)       111,873         0       Anciliary services (from West. D., 20, 3, 11, 020, for Part A, and swing-bed pass-through, see instructions)       111,873         0       Anciliary services (from West. D., 20, 3, 11, 020, for Part B) (for CAH and swing-bed pass-through, see instructions)       0, 1111,873         1.01       Nursing and allied health payment-PARMM or CMART (see instructions)       0, 0, 0         1.01       Nursing and allied health payment-PARMM or CMART (see instructions)       0, 0, 0         1.01       Nursing and allied health payment-PARMM or CMART (see instructions)       0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0	-255 -2	
Title XVIII         Style Beds - SMF         Cost           0         Inpatient routine services - swing bed-WF (see instructions)         399-230           00         Inpatient routine services - swing bed-WF (see instructions)         399-230           01         Ancillary services (from Wast, D-3, col, 3, Line 200, For Part A, and sum of West, D, Part Y, cols, 6 and 7, Line 202, For Part B) (For CAH and swing-bed pass-through, see instructions)         111.873           01         Naria ing and all ide heal th payment-PARHM or CHART (see instructions)         205           01         Instructions for informs and residents not in approved teaching program (see instructions)         0           01         Interns and residents not in approved teaching program (see instructions)         0           03         Subtotal (sum of lines 1 through applicable (sociude amounts applicable to physician professional services)         511.103           04         Subtotal (line 10 ninus line 11)         511.103         511.103           05         Deducting the demonstration payment adjustment (see instructions)         60         509.574           05         Otherstructions)         508.574         0         0           06         Otherstructions)         508.574         0         0           07         Otherstructions)         508.574         0         0         0		
COMPUTATION OF NET COST OF COVERED SERVICES         1.00         2.00           COMPUTATION OF NET COST OF COVERED SERVICES         399, 230         399, 230           Inpattent routine services - swing bed-SNF (see instructions)         399, 230         399, 230           Inpattent routine services - swing bed-SNF (see instructions)         399, 230         11, 873           Part V, Cols, 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)         11, 873         11, 873           Part die cost for interns and residents not in approved teaching program (see instructions)         205         0           Instructions)         100         Subtoal (ine B minus ine 9)         511, 103         0           Of Interns and residents not in approved teaching program (see instructions)         205         511, 103         0           O Interns and residents ine 9)         501, 103         511, 103         0         511, 103           O Subtoal (ine 10 minus ine 1)         511, 103         511, 103         508, 574         508, 574           O OD Subtoal (ine 10 minus ine 1)         511, 103         508, 574         508, 574         508, 574           O OD Subtoal (ine 10 minus ine 1)         511, 103         508, 574         508, 574         508, 574           O OD Subtoal (ine 10 minus ine 1)         501, 100         508, 574		
comPutAtion of PART Cost or CoVERD SERVICES         399, 230           00         Inpatient routine services - swing bed-MF (see instructions)         399, 230           00         Ancillary services (routine services - swing bed-MF (see instructions)         111, 873           01         Ancillary services (routine services - swing bed-MF (see instructions)         111, 873           01         Ancillary services (routine services - swing bed-MF (see instructions)         111, 873           01         Nursing and allied heat th payment-AdMM or CMART (see instructions)         0           01         Per diam cost for Interns and residents not in approved teaching program (see instructions)         0           01         Interns and resident program payments (see instructions)         0           01         Pergram days         0           010         Pergram days         0           010         Subtotal (line to max line 9)         101           010         Subtotal (line to max line 11)         511, 103           010         Subtotal (line to max line 11)         511, 103           010         Subtotal (see instructions)         508, 574           010         OHFM addy subment adjusteent (see instructions)         0           010         OHFM addy subment adjusteent (see instructions)         0           0		
00       Input inter tradition services - swing bed-SK (see instructions)       299,230         01       Input int tradition services - swing bed-SK (see instructions)       200         00       Ancillary services (from Wskt, D-3, col. 3, line 200, for Part A, and sum of Wkst, D, tradition services (from Wskt, D-3, col. 4, line 202, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from Wskt, D-3, col. 3, line 200, for Part B) (from See Instructions)       0111/21/21/21/21/21/21/21/21/21/21/21/21/		
100       Input item tradius services (row West, D., Sci.) 3, line 200, for Part A, and sum of West, D, Part Y, Cols, 6 and 7, line 202, for Part B) (for CAH and swing-bed pass-through, see instructions)       111, 873         101       Mursing and all led health payment-PARM or CUART (see instructions)       0.0         101       Mursing and all led health payment-PARM or CUART (see instructions)       0.0         101       Mursing and slide the payment-PARM or CUART (see instructions)       0.0         101       Mursing and slide the payment payments (see instructions)       0.0         102       Interns and residents not in approved teaching program (see instructions)       0.0         103       Subtotal (sum of lines intertuctions)       0         104       Deductibles billed to program patients (exclude amounts applicable to physician       0         105       Deductibles billed to program patients (from provider records) (exclude coinsurance for physician professional services)       511, 103         103       Obdicitio (see instructions)       506, 574       506, 574         104       Oright Addition (see instructions)       506, 574         105       Phonen (see instructions)       0       0         105       Obdication (see instructions)       0       0         106       Obdication (see instructions)       0       0         107		4
100       Ancillary services (from Wst. D., Ine 200, for Part 8) (for CAH and swingh-bd pass-through, see instructions)       111, 873         Part V, cols. 6 and 7, line 202, for Part 8) (for CAH and swingh-bd pass-through, see instructions)       0         100       Per diem cost for interns and residents not in approved teaching program (see instructions)       0         101       Interns and residents not in approved teaching program (see instructions)       0         101       Interns and residents not in approved teaching program (see instructions)       0         101       Utilization review - physician compensation - SNF optional method only       0         100       Subtotal (see instructions)       0         101       Battotal (line 10 minus line 9)       11, 103         102       Subtotal (line 10 minus line 9)       511, 103         103       Occurational (see instructions)       511, 103         103       Occurational (see instructions)       511, 103         104       Other at costs (line 12 x 963)       500         105       Subtotal (see instructions)       50         106       Other at costs (line 12 x 963)       50         108       Other at costs (line 12 x 963)       50         108       Other at costs (line 12 x 963)       50         109       Otherastotal agustrent amo		1
Part V, Cols. 6 and 7, line 202, for Part B) (for CAH and swing-bod pass-through, see instructions)       0         IN Hursing and all ice heal th payment-PARHM or CHART (see instructions)       0         OP and all costs for interns and residents not in approved teaching program (see instructions)       0         00       Instructions)       205         01       Interns and residents not in approved teaching program (see instructions)       0         02       Utilization review - physician compensation - SNF optional method only       0         03       Subtotal (sum of lines 1 through 3 plus lines 6 and 7)       511,103         04       Deductibles billed to program patients (could amounts applicable to physician       0         05       Subtotal (see instructions)       511,103         06       Deductibles billed to program patients (from provider records) (exclude coinsurance program (see instructions)       511,103         07       Subtotal (see instructions)       508,574         01       Deductible sceles (structions)       508,574         01       Deductible bad debts (see instructions)       0         05       Prome and ustread amount before sequestration       0         05       Prome and ustread amount before sequestration       0         06       Deductible bad debts (see instructions)       0         07<		2
0.1       Nursing and allied heal th payment-PARHM or CHART (see instructions)       0.0         0       Per ofice cost for interns and residents not in approved teaching program (see instructions)       0.0         0       Interns and residents not in approved teaching program (see instructions)       0.0         0       Utilization review - physician compensation - SWF optional method only       0.0         00       Utilization review - physician compensation - SWF optional method only       0.1         00       Butchild (line 8 in miss) line 9       511, 103         00       Boductibles billed to program patients (exclude anounts applicable to physician professional services)       2,529         00       00       00       511, 103       508, 574         00       00       00       511, 103       508, 574         00       00       00       508, 574       508, 574         00       00       100       100, 100, 100, 100, 100, 100, 100, 100,		3
0.00     Per diem cost for interns and residents not in approved teaching program (see instructions)     0.0       0.01     Program days     205       0.02     Interns and residents not in approved teaching program (see instructions)     0       0.01     Ullization review - physician compensation - SNF optional method only     0       0.02     Subtotal (sum of lines 1 through 3 plus lines 6 and 7)     0       0.03     Subtotal (sum of lines 1 through 3 plus lines 6 and 7)     0       0.03     Subtotal (sum of lines 1 through 3 plus lines 6 and 7)     0       0.03     Subtotal (sine 10 minus line 1)     511,103       0.04     Obstotal (see instructions)     511,103       0.05     Subtotal (see instructions)     506,574       0.05     Other Ado demonstration payment adjustment (see instructions)     0       0.05     Pioner Ado demonstration payment adjustment (see instructions)     0       0.06     Atlovasial (see instructions)     0       0.07     Other Ado demonstration payment adjustment (see instructions)     0       0.08     Atlovasial (see instructions)     0       0.07     Other Ado demonstration payment adjustment anount after sequestration     0       0.08     Demonstration payment adjustment anount after sequestration     0       0.08     Other Ado demonstration payment adjustment anount after sequestration <td></td> <td>3</td>		3
instructions)       1000000000000000000000000000000000000		4
00       Interns and residents not in approved teaching program (see instructions)       0         00       Utilization review - physician compensation - SNF optional method only       50         00       Subtotal (sum of lines 1 through 3 plus lines 6 and 7)       511,103         01       Deductibles billed to program patients (seclude amounts applicable to physician professional services)       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Colonsurance billed to program patients (seclude amounts applicable to physician professional services)       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       511,103       511,103         0.00       Subtotal (line 10 minus line 11)       508,574       508,574         0.01       Superstration apyment adjustment (see instructions)       0       0         0.01       Superstration apym		
00       Utilization review - physician compensation - SNF optional method only       0         00       Subtotal (sum of lines 1 through a plus lines 6 and 7)       0         01       0       Subtotal (line 8 minus line 9)       0         02       00       Subtotal (line 10 minus line 11)       511,103         03       00       0       511,103       0         04       00       0       511,103       0         05       01       01       01       01         04       00       01       01       01         05       01       01       01       01         06       01       01       01       01       01         07       01       01       01       01       01       01         08       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       01       0	0	5
00       Subtotal (sum of lines 1 through 3 plus lines 6 and 7)       511,103         00       Primary payer payere payere (see instructions)       0         0.00       Subtotal (line 8 minus line 9)       511,103         0.00       Deductibles billed to program patients (exclude amounts applicable to physician professional services)       511,103         0.00       Subtotal (line 10 minus line 11)       511,103         0.00       Subtotal (see instructions)       508,574         0.00       Subtotal (see instructions)       508,574         0.00       OffHER ADUSTINENTS (SEE INSTRUCTIONS) (SPECIFY)       508,574         0.01       OffHER ADUSTINENTS (See instructions)       0         0.01       Official bad debts (see instructions)       0         0.02       Sequestration adjustment amount after sequestration)       0         0.01       Official bad debts (	0	6
00     Primary payer payments (see instructions)     0       00     Subtotal (line B minus line 9)     0       1.00     Deductibles billed to program patients (exclude amounts applicable to physician professional services)     511,103       2.00     Subtotal (line 10 minus line 11)     511,103       00     Obstrance billed to program patients (from provider records) (exclude coinsurance for physician professional services)     511,103       00     OB 0% of Part B costs (line 12 x 80%)     508,574       00     Otter ADUSTMENTS (SEE INSTRUCtiONS) (SPECIFY)     508,574       0.50     Subtotal (see instructions)     0       6.50     Forneer ACD demonstration project (\$410A Demonstration) payment adjustment adjustment adjustment and contraction payment adjustment adjustment adjustment adjustment (see instructions)     0       0.51     Demonstration payment adjustment amount before sequestration     0       0.51     Ottal (see instructions)     0       0.52     Sequestration adjustment (see instructions)     0       0.53     Sequestration adjustment (for contractor use only)     0       0.54     Sequestration adjustment PARHW or CHART (for contractor use only)     0       0.55     Interim		7.
0.00       Subtotal (line 3 minus line 9)       511.103         0.00       Deductibles billed to program patients (exclude amounts applicable to physician professional services)       511.103         0.00       Subtotal (line 10 minus line 11)       511.103         3.00       Coinsurance billed to program patients (from provider records) (exclude coinsurance from physician professional services)       508.574         0.00       Subtotal (see instructions)       508.574         0.00       OTHER ADUSTIBUTS (SEE INSTRUCTIONS) (SPECIFY)       0         6.00       OTHER ACD demonstration project (\$410A Demonstration) payment adjustment (see instructions)       0         6.00       Demonstration payment adjustment (see instructions)       0         6.00       Demonstration payment adjustment (see instructions)       0         7.01       Adjusted reimbursable bad debts (see instructions)       0         9.00       Foral physical Professional Services)       6.408         9.01       Demonstration payment adjustment amount after sequestration)       0         9.02       Demonstration of non-claims based amounts (see instructions)       0         9.03       Sequestration adjustment-PARMH or CHART pass-throughs       0         9.05       Sequestration adjustment Age enstructions)       0         9.11       Tentative settlement-FARMH or	0	8
1.00       Deductibles billed to program patients (exclude amounts applicable to physician professional services)       0         2.00       Subtotal (line 10 minus line 11)       511.103         3.00       Consurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)       511.103         3.00       Subtotal (see instructions)       508.574         5.00       Subtotal (see instructions)       508.574         6.00       OTHER ADUSTINENTS (SEE INSTRUCTIONS) (SPECIFY)       508.574         6.50       Profeseration payment adjustment (see instructions)       0         6.59       Penonstration payment adjustment (see instructions)       0         7.00       Allowable bad debts (see instructions)       0         7.01       Aljusted relimbursahe bad debts (see instructions)       0         9.01       Sequestration adjustment (see instructions)       0         9.02       Demonstration payment adjustment (see instructions)       0         9.03       Sequestration on dustment AdART pass-throughs       0         9.04       Sequestration on-claims based amounts (see instructions)       0         9.05       Sequestration of program (Alart Pass-throughs       0         9.02       Demonstration payments       472, 316         10.01		9
professional services)         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1		10
2.00       Subtotal (line 10 minus line 11)       511,103         0.00       Consumance billed to program patients (from provider records) (exclude coinsurance       2,529         0.00       Display (line 12 x 80%)       508         5.00       Subtotal (see instructions)       508,574         6.00       OHER ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         6.50       Pioneer AC0 demonstration payment adj ustment (see instructions)       0         6.50       Poment adj ustment amount before sequestration       0         7.00       Allowable bad debts (see instructions)       0         8.00       Allowable bad debts (see instructions)       0         9.01       Sequestration adj ustment (see instructions)       0         9.02       Demonstration payment adj ustment amount after sequestration)       0         9.03       Sequestration adj ustment (see instructions)       0         9.04       Demonstration payment adj ustment amount after sequestration)       0         9.03       Sequestration on-clains based amounts (see instructions)       0         9.03       Sequestration for non-clains based amounts (see instructions)       0         9.04       Demonstration payment adj ustment (see instructions)       0         9.05       Sequestration for non-clains based amounts (see inst	0 1	11.
3.00       Coinsurance billed to program patients (from provider records) (exclude coinsurance for provided for the constructions)       2,529         4.00       80% of Part B costs (line 12 x 80%)       508,574         5.00       Subtotal (see instructions)       508,574         6.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       508,574         6.50       Pioneer ACO demonstration payment adjustment (see instructions)       0         6.90       Demonstration payment adjustment amount before sequestration       0         7.01       Adjusted reinbursable bad debts (see instructions)       0         9.00       Total (see instructions)       0         9.01       Sequestration adjustment (see instructions)       508,574         9.02       Demonstration payment adjustment sequestration)       0         9.03       Sequestration adjustment ANART pass-throughs       0         9.04       Interlin payments       0         9.05       Sequestration on on-clains based amounts (see instructions)       0         9.01       Interlin payments       0         9.02       Interlin payments       0         9.03       Sequestration on diustment -PARM or CHART       (see instructions)       0         9.03       Interlin paymentsexPARM or CHART (see instructions)       0 <td></td> <td>1-</td>		1-
For physician professional services)       500         00 80% of Part B costs (line 12 x 80%)       500         5.00       Subtotal (see instructions)       500         6.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       500         6.55       Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)       0         6.55       Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)       0         6.70       All owable bad debts (see instructions)       0         7.01       Adjusted relinbursable bad debts (see instructions)       0         9.00       Total (see instructions)       508,574         9.01       Sequestration adjustment Amount after sequestration       0         9.02       Demonstration for non-claims based amounts (see instructions)       0         9.25       Sequestration adjustment/FARMM or CHART pass-throughts       0         9.20       Interim payments-PARMM or CHART pass-throughts       472, 316         0.11       Interim payments-PARMM or CHART (for contractor use only)       0       0         1.01       Tentative settlement (for contractor use only)       0       0         1.01       Tentative settlement -PARMM or CHART (see instructions)       0       0 <tr< td=""><td></td><td>12</td></tr<>		12
4.00       80% of Part B costs (line 12 x 80%)         5.00       Subtotal (see instructions)       508,574         6.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       508,574         6.01       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         6.55       Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)       0         6.90       Demonstration payment adjustment amount before sequestration       0         7.00       All owable bad debts (see instructions)       0         8.00       All owable bad debts (see instructions)       0         9.01       Total (see instructions)       0         9.02       Demonstration payment adjustment amount after sequestration)       6,408         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration on on-on-claims based amounts (see instructions)       0         9.03       Sequestration on on-on-CHART       472,316         1.00       Interim payments.       472,316         1.01       Interim payment-PARHM or CHART       472,316         1.00       Interim payment-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (for contractor use only)       0 <td>0 1</td> <td>13</td>	0 1	13
5.00       Subtotal (see instructions)       508,574         6.00       OTHER ADJUSTMENT (SEE INSTRUCTIONS) (SPECIFY)       0         6.55       Prioneer ACO demonstration payment adjustment (see instructions)       0         6.56       Prioneer ACO demonstration payment adjustment (see instructions)       0         6.57       Aural community hospital demonstration project (\$410A Demonstration) payment       0         7.01       Adjustment (see instructions)       0         7.01       Adjustment (see instructions)       0         9.00       Total (see instructions)       508,574         9.01       Sequestration adjustment Amount after sequestration)       0         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration adjustment (ARM or CHART Sequestrations)       0         9.25       Sequestration adjustment (for contractor use only)       0         0.01       Interim payments (nonallowable cost report items) in accordance with CMS Pub. 15-2, o       0         0.01       Sequestration adjustment (For contractor use only)       0       0         1.01       Tentative settlement (For contractor use only)       0       0         1.01       Tentative settlement for cortractor use only)       0       0	0 1	14
6 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         6 00       Pioneer AC0 demonstration payment adjustment (see instructions)       0         6 01       Diemeer AC0 demonstration payment adjustment (see instructions)       0         6 02       Diemestration payment adjustment amount before sequestration       0         6 03       Demonstration payment adjustment amount before sequestration       0         7.00       All owable bad debts (see instructions)       0         7.01       Aljusted reindursable bad debts (see instructions)       0         8.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         9.01       Total (see instructions)       508, 574         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration on on-ol alms based amounts (see instructions)       0         9.03       Interim payments       472, 316         0.04       Interim payments-PARHM or CHART (see instructions)       0         1.00       Tentative settlement (APR or CHART (see instructions)       0         2.00       Balance due provider/program (Iine 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program PARHM or CHART (see instructions)       0      <		14
6.50       Ploneer AC0 demonstration payment adjustment (see instructions)       0         6.55       Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)       0         6.90       Demonstration payment adjustment amount before sequestration       0         7.01       Allowable bad debts (see instructions)       0         8.01       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         9.02       Total (see instructions)       508,574         9.03       Sequestration adjustment Amount after sequestration)       0         9.03       Sequestration adjustment Amount after sequestrations)       0         9.03       Sequestration adjustment Apress-throughs       0         9.11       Interim payments       472,316         0.11       Interim payments-PARHM or CHART       0         1.00       Tentative settlement (for contractor use only)       0         2.00       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29.850         3.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0       0         Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment       0         0.00       Is thefits thefits year of the current 5-year demonstration period under		16
6.55       Rural community hospital demonstration project (\$410A Demonstration) payment       0         6.99       Demonstration payment adjustment amount before sequestration       0         7.00       Allowable bad debts (see instructions)       0         7.01       Adjusted reimbursable bad debts (see instructions)       0         8.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         9.01       Sequestration adjustment (see instructions)       6,408         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration on justment amount after sequestration)       0         9.04       Sequestration for non-claims based amounts (see instructions)       0         9.05       Bealence due provider/program-PARHM or CHART       472, 316         9.01       Interim payments-PARHM or CHART (for contractor use only)       0         9.01       Balance due provider/program-PARHM or CHART (see instructions)       472, 316         9.01       Balance due provider/program-PARHM or CHART (see instructions)       29, 850         9.01       Balance due provider/program-PARHM or CHART (see instructions)       472, 316         9.01       Balance due provider/program-PARHM or CHART (see instructions)       29, 850         9.01       Balance due provid		16
adj ustment (seé instructions)       0         6 99       Demonstration payment adj ustment amount before sequestration       0         7:00       Allowable bad debts (see instructions)       0         8:00       Allowable bad debts (see instructions)       0         9:01       Sequestration adj ustment family beneficiaries (see instructions)       0         9:00       Total (see instructions)       508,574         9:02       Demonstration payment adj ustment amount after sequestration)       508,574         9:03       Sequestration adj ustment -PARHM or CHART pass-throughs       0         9:25       Sequestration adj ustment -PARHM or CHART (for contractor use only)       0         1:00       Interim payments       472,316         0:11       Interim payments       472,316         0:01       Interim payments       0         1:00       Tentative settlement (for contractor use only)       0         1:01       Tentative settlement PARHM or CHART (for contractor use only)       0         1:02       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29, 850         3:00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, colectapter 1, \$115.2       0         Rural Community Hospital Demonstration Project (\$410A Demonstration) Ad		16
6.99       Demonstration payment adjustment amount before sequestration       0         7.00       Allowable bad debts (see instructions)       0         7.01       Adjusted reimbursable bad debts (see instructions)       0         8.00       Allowable bad debts (see instructions)       0         9.01       Total (see instructions)       508,574         9.01       Sequestration adjustment (see instructions)       6,408         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration of non-claims based amounts (see instructions)       0         9.04       Interim payments       0         9.05       Interim payments       0         9.01       Balance due provider/porgram-PARHM or CHART       (see inst	'	10
7.00       Allowable bad debts (see instructions)       0         7.01       Adjusted reimbursable bad debts (see instructions)       0         8.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         9.00       Total (see instructions)       508,574         9.01       Sequestration adjustment sequestration)       6,408         9.02       Demonstration payment adjustment ARMM or CHART pass-throughs       0         9.25       Sequestration adjustment PARMM or CHART pass-throughs       0         9.00       Interim payments-PARMM or CHART (for contractor use only)       0         1.00       Interim payments-PARMM or CHART (for contractor use only)       0         2.00       Balance due provider/program (line 19 minus lines 19.01, 19,02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program-PARMM or CHART (see instructions)       0         2.02       Balance due provider/program (For contractor use only)       20         2.03       Balance due provider/program PARMM or CHART (see instructions)       10         2.00       Ist is the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.         2.01       Ist ist we stilembursement       10         0.020       Nedicare swing-bed SNF inpatient ancillary servi	0 1	16
7.01       Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)       0         8.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         9.01       Total (see instructions)       508,574         9.01       Sequestration adjustment (see instructions)       6,408         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration of non-claims based amounts (see instructions)       0         9.04       Interim payments       472,316         0.05       Interim payments-PARHM or CHART       472,316         0.06       Interim payments-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement (for contractor use only)       0         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         3.00       Protested amounts (nonal lowable cost report items) in a cordance with CMS Pub. 15-2, o       0         chapter 1., \$115.2       Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment       0         0.10       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement       0		17
8.00       Al [*] owable bad debts for dual eligible beneficiaries (see instructions)       0         9.00       Total (see instructions)       508,574         9.01       Sequestration adjustment (see instructions)       6,408         9.02       Demonstration payment adjustment amount after sequestration)       0         9.03       Sequestration adjustment-PARHM or CHART pass-throughs       0         9.25       Sequestration for non-claims based amounts (see instructions)       0         0.01       Interim payments-PARHM or CHART       472,316         0.01       Interim payments-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (for contractor use only)       0         1.02       Balance due provider/program (line 19 minus lines 19,01, 19,02, 19,25, 20, and 21)       29,850         3.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0       0         chapter 1, \$115, 2       0       0         0.10       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. 11, line 66 (title XVIII hospital)       0         0.10       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 200 (title XVIII hospital)       0         0.00       Medicare swing-bed SNF inpatient toutine cost cap (line 205 times line 204)       0	0 1	17
9.01 Sequestration adj ustment (see instructions) 6.408 9.02 Demonstration payment adj ustment amount after sequestration) 0 9.03 Sequestration adj ustment-PARHM or CHART pass-throughs 0 9.25 Sequestration for non-claims based amounts (see instructions) 0 0.01 Interim payments - PARHM or CHART 472, 316 0.01 Interim payments-PARHM or CHART (for contractor use only) 0 1.01 Tentative settlement-PARHM or CHART (for contractor use only) 0 2.00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 29,850 2.01 Balance due provider/program.PARHM or CHART (see instructions) 0 0.01 Interim typested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 chapter 1, \$115.2 Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment 00.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "\" for yes or "\" for no. Cost Reimbursement 01.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII swing-bed SNF)) 02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 201 (sum of lines 201 and 202) 04.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 07.00 Program reimbursement under the \$410A Demonstration (see instructions) 08.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare swing-bed SNF Inpatient Reimbursement 07.00 Program reimbursement under the \$410A Demonstration (see instructions) 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09.00 Adjustment to Medicare swing-bed SNF PS payments (see instructions) 00.00 Reserved for future use	0 1	18
9.01 Sequestration adjustment (see instructions) 6.408 9.02 Demonstration payment adjustment amount after sequestration) 0 9.03 Sequestration adjustment-PARHM or CHART pass-throughs 0 9.25 Sequestration for non-claims based amounts (see instructions) 0 1.00 Interim payments 472, 316 1.01 Tentative settlement (for contractor use only) 0 1.01 Tentative settlement PARHM or CHART (for contractor use only) 0 2.08 Balance due provider/program (line 19 minus lines 19, 01, 19.02, 19.25, 20, and 21) 29, 850 2.01 Balance due provider/program.PARHM or CHART (see instructions) 0 0.01 Interim contist (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0.02 Chapter 1, §115.2 0.03 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 00.00 Is this the first year of the current 5-year demonstration period under the 21st 0.100 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII swing-bed SNF)) 02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 02.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 04.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 05.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 05.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Program reimbursement under the §410A Demonstration (see instructions) 09.00 Adjustment to Medicare swing-bed SNF PS payments (see instructions) 09.00 Adjustment to Medicare swing-bed SNF PS payments (see instructions) 09.00 Adjustment to Medicare swing-bed SNF PS payments (see instructions)	0 1	19
9.03       Sequestration adjustment-PARHM or CHART pass-throughs       0         9.25       Sequestration for non-claims based amounts (see instructions)       0         9.26       Sequestration for non-claims based amounts (see instructions)       0         0.01       Interim payments       472, 316         0.01       Interim payments       0         1.00       Tentative settlement-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (see instructions)       0         2.00       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29, 850         3.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0       0         chapter 1, §115.2       Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.       0         01.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. II, line 66 (tite XVII hospital)       0         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (tite XVII swing-bed SNF)       0	0 1	19
9.25       Sequestration for non-claims based amounts (see instructions)       0         0.00       Interim payments       0         0.10       Interim payments-PARHM or CHART       0         1.00       Tentative settlement (for contractor use only)       0         1.01       Tentative settlement (for contractor use only)       0         1.01       Tentative settlement (for contractor use only)       0         2.01       Bal ance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Bal ance due provider/program-PARHM or CHART (see instructions)       0         3.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       0         Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment       00         00.00       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "V" for yes or "N" for no.       0         Cost Reimbursement       0       00       00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII swing-bed SNF))       0         020.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200       0         030.00       Total (sum of lines 201 and 202)       0       0      <	0 1	19
0.00       Interim payments       472, 316         0.01       Interim payments-PARHM or CHART       0         1.00       Tentative settlement (for contractor use only)       0         2.00       Bal ance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.00       Bal ance due provider/program-PARHM or CHART (see instructions)       20,00         3.00       Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, cold       0         chapter 1, §115.2       0       0         Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       Is this the first year of the current 5-year demonstration period under the 21st       0         Cost Reimbursement       Cost Reimbursement       0         01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (it le XVIII hospital))       0         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)       0         03.00       Total (sum of lines 201 and 202)       0       0         04.00       Medicare swing-bed SNF target amount       0         05.00       Medicare swing-bed SNF target amount       0         06.00       Medicare swing-bed SNF targe	1	19
0.01       Interim payments-PARHM or CHART       0         1.00       Tentative settlement (for contractor use only)       0         1.01       Tentative settlement (for contractor use only)       0         2.00       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       0         0.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0       0         chapter 1, §115.2       Rural Community Hospital Demonstration Project (§410A Demonstration period under the 21st       0         Contury Cures Act? Enter "Y" for yes or "N" for no.       Cost Reimbursement       0         0.00       Nedicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. 11, line 66 (title XVIII hospital))       0         0.200       Medicare swing-bed SNF discharges (see instructions)       0         0.30.00       Total (sum of lines 201 and 202)       0         0.40       Medicare swing-bed SNF discharges (see instructions)       0         0.00       Medicare swing-bed SNF target amount       0         0.01       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)       <	0 1	19
1.00       Tentative settlement (for contractor use only)       0         1.01       Tentative settlement-PARHM or CHART (for contractor use only)       0         2.00       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         3.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0       0         chapter 1, §115.2       Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.       0         01.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-1, Pt. 11, line 66 (title XVIII hospital))       0         02.00       Medicare swing-bed SNF di scharges (see instructions)       0         03.00       Total (sum of lines 201 and 202)       0         04.00       Medicare swing-bed SNF di scharges (see instructions)       0 <td>0 2</td> <td>20</td>	0 2	20
1.01       Tentative settlement-PARHM or CHART (for contractor use only)       2.00       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.10       Balance due provider/program ARHM or CHART (see instructions)       29,850         0.11       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.11       Balance due provider/program ARHM or CHART (see instructions)       20,850         0.11       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.11       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.11       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.11       Balance due provider/program (Line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         0.11       State Community Hospital Demonstration Project (§410A Demonstration Adjustment       01.00         0.02       Is this the first year of the current 5-year demonstration period under the 21st       01.00         0.03       Edicare swing-bed SNF inpatient routine service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))       03.00         0.04       Odicare swing-bed SNF discharges (see instructions)       00.00         0.04       Medicare swing-bed SNF target amount <td></td> <td>20</td>		20
2.00       Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)       29,850         2.01       Balance due provider/program-PARHM or CHART (see instructions)       29,850         0.01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0       0         chapter 1, §115.2       Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "\" for yes or "N" for no.       0         Cost Reimbursement       0       00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))       0         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))       0         03.00       Total (sum of lines 201 and 202)       0       0         04.00       Medicare swing-bed SNF target amount 0       0       0         05.00       Medicare swing-bed SNF target amount 202       0       0       0         05.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)       4       4         06.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)       0       0         05.00		21
2.01       Balance due provider/program-PARHM or CHART (see instructions)       0         3.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0         Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.       0         01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))       0         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))       0         03.00       Total (sum of lines 201 and 202)       0         04.00       Medicare swing-bed SNF target amount       0         05.00       Medicare swing-bed SNF target amount       0         06.00       Medicare swing-bed SNF target amount       0         05.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)       4         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement       0       0         07.00       Program reimbursement under the §410A Demonstration (see instructions)       0         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)       0		21
3.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2.       0         Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment       0         00.00       1s this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement       0         01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))       0         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))       0         03.00       Total (sum of lines 201 and 202)       0         04.00       Medicare swing-bed SNF discharges (see instructions)       0         05.00       Medicare swing-bed SNF target amount       1mitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF target amount       205 times line 204)       4         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement       70.00       Program reimbursement under the §410A Demonstration (see instructions)       1         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)       0       1         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)       1       1       1		22
chapter 1, §115.2       Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment         00.00 Is this the first year of the current 5-year demonstration period under the 21st		22
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment         00.00       Is this the first year of the current 5-year demonstration period under the 21st         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         01.00         Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line         66 (title XVIII hospital))         02.00         02.00         Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line         200 (title XVIII swing-bed SNF))         03.00         040 (care swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration         05.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         00.00       Medicare swing-bed SNF PPS payments (see instructions)         01.00       Reserved for future use	0 2	23
00.00       Is this the first year of the current 5-year demonstration period under the 21st         Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))         03.00       Total (sum of lines 201 and 202)         04.00       Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF target amount         06.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         00.00       Reserved for future use		
Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         01.00         Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line         66 (title XVIII hospital))         02.00         Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line         200 (title XVIII swing-bed SNF))         03.00         Total (sum of lines 201 and 202)         04.00         Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adj ustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         01.00       Reserved for future use		200
Cost Reimbursement         01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line         66 (title XVIII hospital))         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line         200 (title XVIII swing-bed SNF))         03.00       Total (sum of lines 201 and 202)         04.00       Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF target amount         06.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         09.00       Reserved for future use	20	.00
01.00       Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line         66 (title XVIII hospital))       02.00         02.00       Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line         200 (title XVIII swing-bed SNF))       03.00         03.00       Total (sum of lines 201 and 202)         04.00       Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         00       Reserved for future use		
66 (title XVIII hospital))         02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line         200 (title XVIII swing-bed SNF))         03.00 Total (sum of lines 201 and 202)         04.00 Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00 Medicare swing-bed SNF target amount         06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00 Program reimbursement under the §410A Demonstration (see instructions)         08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         09.00 Reserved for future use	20	201
200 (title XVIII swing-bed SNF))         03.00 Total (sum of lines 201 and 202)         04.00 Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00 Medicare swing-bed SNF target amount         06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00 Program reimbursement under the §410A Demonstration (see instructions)         08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         10.00 Reserved for future use		
03.00       Total (sum of lines 201 and 202)         04.00       Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF target amount         06.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         10.00       Reserved for future use	20	202
04.00       Medicare swing-bed SNF discharges (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)         05.00       Medicare swing-bed SNF target amount         06.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adj ustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         10.00       Reserved for future use		
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 25.00 Medicare swing-bed SNF target amount 26.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 27.00 Program reimbursement under the §410A Demonstration (see instructions) 28.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 29.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use	20	203
period)         D5.00         Medicare swing-bed SNF target amount         D6.00         Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         D7.00         Program reimbursement under the §410A Demonstration (see instructions)         D8.00         Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         D9.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         D0.00       Reserved for future use	20	204
D5.00       Medicare swing-bed SNF target amount         D6.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         D7.00       Program reimbursement under the §410A Demonstration (see instructions)         D8.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         D9.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         D9.00       Adjustment to for future use		
06.00       Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)         Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00       Program reimbursement under the §410A Demonstration (see instructions)         08.00       Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00       Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         10.00       Reserved for future use		
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement         07.00 Program reimbursement under the §410A Demonstration (see instructions)         08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)         09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)         10.00 Reserved for future use		205
07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use	20	206
08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use	-	~ 7
and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use		207
09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use	20	208
10.00 Reserved for future use	20	000
		209
Comparision of PPS versus Cost Reimbursement	-  ²	10
15.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see	121	215

ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2022 To 12/31/2022		epare
	·	Title XVIII	Hospi tal	Cost	-
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	T RELMBURSEMENT	1.00	
00	Inpatient services			1, 266, 107	1 1
00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	
00	Organ acquisition			0	
01	Cellular therapy acquisition cost (see instructions)			0	3
00	Subtotal (sum of lines 1 through 3.01)			1, 266, 107	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructions)	)		1, 278, 768	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges			0	10
	Customary charges			-	l
. 00	Aggregate amount actually collected from patients liable for				11
2. 00	Amounts that would have been realized from patients liable	1 3	on a charge basis	0	12
00	had such payment been made in accordance with 42 CFR 413.13	3(e)		0. 000000	12
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
. 00	Total customary charges (see instructions)	only if line 14 exceeds 1	100 (000		14
. 00	Excess of customary charges over reasonable cost (complete instructions)	Unity IT TTTE 14 exceeds I	The of (see	U	15
. 00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds li	ne 14) (see	0	16
. 00	instructions)	only in the blexeeds in	10 14) (300	0	'0
. 00	Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<b>F</b> ( ) ( )			1
3.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)			18
. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 278, 768	
. 00	Deductibles (exclude professional component)			154, 044	
. 00 . 00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			0 1, 124, 724	
. 00	Coi nsurance			1, 124, 724	
. 00	Subtotal (line 22 minus line 23)			1, 124, 724	
. 00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		12, 839	
. 00	Adjusted reimbursable bad debts (see instructions)			8, 345	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		353	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 133, 069	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instructi	i ons)		Ő	
. 98	Recovery of accel erated depreciation.	,		Ō	
. 99	Demonstration payment adjustment amount before sequestration	on		0	
. 00	Subtotal (see instructions)			1, 133, 069	
. 01	Sequestration adjustment (see instructions)			14, 277	30
. 02	Demonstration payment adjustment amount after sequestration	n		0	30
. 03	Sequestration adjustment-PARHM or CHART				30
. 00	Interim payments			931, 327	31
. 01	Interim payments-PARHM or CHART				31
. 00	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM or CHART (for contractor use on	57			32
2. 01	Balance due provider/program (line 30 minus lines 30.01, 30			187, 465	
2. 01 3. 00			00 01 01		33
2. 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18	8, and 26, minus lines 30.	03, 31.01, and		33
2. 01 8. 00	32.01)			0	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: rom 01/01/2022 o 12/31/2022	Worksheet G Date/Time Pre 5/26/2023 4:0	
		General Fund	Speci fi c Purpose Fund	Endowment Fund 3.00	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	1, 757	0	0	0	1.0
	Temporary investments	0		0	0	1
	Notes receivable		0	0	0	3.0
	Accounts receivable Other receivable	6, 835, 723 8, 941	0	0	0	4.0
	Allowances for uncollectible notes and accounts receivable	0, 941	0	0	0	6.0
	Inventory	389, 198	-	0	0	1
00	Prepai d'expenses	17, 735	0	0	0	8.0
	Other current assets	0	-	0	0	1
	Due from other funds	6, 173, 643		0	0	10.0
	Total current assets (sum of lines 1-10)	13, 426, 997	0	0	0	11.0
	FI XED ASSETS Land	320, 702	0	0	0	12.0
	Land improvements	2,011,654		0	0	13.0
	Accumulated depreciation	-1, 466, 108		0	0	1
	Buildings	13, 256, 634		0	0	
	Accumulated depreciation	-5, 444, 355		0	0	16.0
	Leasehold improvements	15, 320	0	0	0	17.0
	Accumulated depreciation	-15, 320		0	0	18.0
	Fixed equipment	9, 055, 505		0	0	19.0
	Accumulated depreciation	-7, 441, 712		0	0	20.
	Automobiles and trucks	61, 324		0	0	21.
	Accumulated depreciation Major movable equipment	-61, 324 10, 770, 990		0	0	22. 23.
	Accumul ated depreciation	-8, 539, 665		0	0	23.
	Mi nor equipment depreciable	-0, 339, 003	0	0	0	24.
	Accumulated depreciation		0	0	0	26.
	HIT designated Assets	0	0	0	0	27.
	Accumulated depreciation	0	0	0	0	28.
	Minor equipment-nondepreciable	0	0	0	0	29.
	Total fixed assets (sum of lines 12-29)	12, 523, 645	0	0	0	30.
	OTHER ASSETS Investments	0	0	0	0	31.
	Deposits on Leases			0	0	
	Due from owners/officers		0	0	0	33.
	Other assets	5, 011, 241	0	0	0	34.
. 00	Total other assets (sum of lines 31-34)	5, 011, 241		0	0	35.
. 00	Total assets (sum of lines 11, 30, and 35)	30, 961, 883	0	0	0	36.
	CURRENT LIABILITIES	r	1			_
	Accounts payable	1,031,106		0	0	37.
	Salaries, wages, and fees payable Payroll taxes payable	717, 152 0		0	0	
	Notes and Loans payable (short term)	1, 080, 000	0	0	0	
	Deferred income	1,000,000	0	0	0	
	Accelerated payments	0	_	-		42.
. 00	Due to other funds	0	0	0	0	43.
	Other current liabilities	1, 381, 112		0	0	44.
. 00	Total current liabilities (sum of lines 37 thru 44)	4, 209, 370	0	0	0	45.
	LONG TERM LIABILITIES	-	-	-		l
	Mortgage payable	0	0	0	0	
	Notes payable Unsecured Loans	0	0	0	0	
	Other long term liabilities	12, 347, 790	0	0	0	48.
	Total long term liabilities (sum of lines 46 thru 49)	12, 347, 790		0	0	1
	Total liabilities (sum of lines 45 and 50)	16, 557, 160		0	0	51.
	CAPI TAL ACCOUNTS					
. 00	General fund balance	14, 404, 723				52.
	Specific purpose fund		0			53.
	Donor created - endowment fund balance - restricted			0		54.
	Donor created - endowment fund balance - unrestricted			0		55.
	Governing body created - endowment fund balance			0	-	56.
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58.
. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	14, 404, 723	0	0	0	59.
	TOTAL FUND DALANCES (SUIL OF TIMES 32 LINU 30)	1 14,404,723	0	0	0	1 07.

Health Financial Systems         F           STATEMENT OF CHANGES IN FUND BALANCES         F		PARKVI EW LAGRANO	Provi der CC	CN: 15-1323	Period: From 01/01/2022	u of Form CMS- Worksheet G-	
					To 12/31/2022	Date/Time Pro	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	-	1.00	2.00	3.00	4,00	5.00	
2.00 Net 3.00 Tot 4.00 Add 5.00 6.00 7.00 8.00 9.00 Tot 11.00 Sub 12.00 OTH 13.00 15.00 14.00 15.00 16.00 17.00 Tot 18.00 Tot 19.00 Fun	nd balances at beginning of period t income (loss) (from Wkst. G-3, line 29) tal (sum of line 1 and line 2) ditions (credit adjustments) (specify) tal additions (sum of line 4-9) btotal (line 3 plus line 10) HER tal deductions (sum of lines 12-17) nd balance at end of period per balance eet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	258, 945 14, 404, 723	3.00			5.00         6.00         7.00         8.00         9.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
2.00 Net 3.00 Tot	nd balances at beginning of period t income (loss) (from Wkst. G-3, line 29) tal (sum of line 1 and line 2) ditions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00         Tot           11.00         Sub           12.00         OTH           13.00         It           14.00         It           15.00         It           17.00         It		0 0	0 0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
19.00 Fun	tal deductions (sum of lines 12-17) nd balance at end of period per balance eet (line 11 minus line 18)	0 0			0 0		18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1323	Peri Fron To	od: n 01/01/2022 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre 5/26/2023 4:0	pared:
	Cost Center Description	_	Inpati ent	(	Dutpatient	Total	
	PART I – PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						-
1.00	Hospi tal		11, 157, 9	64	1	11, 157, 964	1.00
2.00	SUBPROVIDER - IPF		11, 137, 9	04		11, 157, 904	2.00
2.00	SUBPROVIDER - IRF						3.00
3.00 4.00	SUBPROVIDER - TRF						4.00
4.00 5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - SNF			0		0	6.00
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSING FACILITY						8.00
8.00 9.00	OTHER LONG TERM CARE						9.00
9.00			11 157 0	41		11 157 044	10.00
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		11, 157, 9	04	I	11, 157, 964	10.00
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
12.00	BURN INTENSIVE CARE UNIT						12.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
14.00							14.00
	OTHER SPECIAL CARE (SPECIFY)	Linco		0		0	
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	Times		0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		11, 157, 9	41		11, 157, 964	17.00
18.00	Ancillary services		16, 628, 9		79, 618, 418	96, 247, 389	17.00
19.00	Outpatient services		1, 122, 5		28, 988, 073	30, 110, 642	
20.00	RURAL HEALTH CLINIC		1, 122, 5			30, 110, 642	20.00
				0 0	0	0	
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							24.00
25.00	AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE						25.00
26.00			00.7	~~	102.070	11 070	26.00
27.00	Other Patient Service Revenue		92, 7		-103, 868	-11,078	
27.01	Other Patient Service Revenue - NRCCs	to Whet	193, 9		5,043,143	5, 237, 100	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to wkst.	29, 196, 2	51	113, 545, 766	142, 742, 017	28.00
	G-3, line 1) PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)	I			39, 600, 176		29.00
30.00			347, 1	74	39, 600, 176		30.00
	Nonallowable Home Office Interest Expense		347,1	0			
31.00				0			31.00
32.00							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)			~	347, 174		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0	_		41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	(transfer)		1	39, 947, 350		43.00

Heal th	Financial Systems	PARKVI EW LAGRANGE	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	F	rovider CCN: 15-1323	Period: From 01/01/2022	Worksheet G-3	
				To 12/31/2022		
					5/26/2023 4:0	z pili
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa	rt I, column 3, line	28)		142, 742, 017	1.00
2.00	Less contractual allowances and discounts	on patients' accounts	, , , , , , , , , , , , , , , , , , ,		100, 599, 260	2.00
3.00	Net patient revenues (line 1 minus line 2)				42, 142, 757	3.00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line 43	5)		39, 947, 350	4.00
5.00	Net income from service to patients (line	3 minus line 4)			2, 195, 407	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				-3, 317	7.00
8.00	Revenues from telephone and other miscella	neous communication s	ervi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	
13.00	Revenue from laundry and linen service				0	
	Revenue from meals sold to employees and g	uests			290, 913	14.00
	<b>J</b>				0	15.00
	Revenue from sale of medical and surgical		n patients		0	
	Revenue from sale of drugs to other than p				29, 414	17.00
	Revenue from sale of medical records and a				0	
19.00	Tuition (fees, sale of textbooks, uniforms	, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			21, 815	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				40, 733	22.00
23.00	Governmental appropriations				136, 420	23.00
24.00	OTHER (SPECIFY)				0	
	MI SCELLANEOUS OTHER OPERATING				30, 832	24.02
24.50	COVI D-19 PHE Fundi ng				0	
25.00	Total other income (sum of lines 6-24)				546, 810	25.00
	Total (line 5 plus line 25)				2, 742, 217	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and s				0	28.00
29.00	Net income (or loss) for the period (line :	26 minus line 28)			2, 742, 217	29.00