Heal th Financi	al Systems	PARKVI EW WABASH HOS	SPITAL, INC.	In Lieu	of Form CMS-2552-10
This report is	s required by law (42 USC 1395g; 42	CFR 413.20(b)). Fai	lure to report can res	ult in all interim	FORM APPROVED
payments made	since the beginning of the cost rep	porting period being	g deemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 09-30-2025
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST RE SUMMARY	EPORT CERTIFICATION	Provi der CCN: 15-1310		Worksheet S Parts I-III Date/Time Prepared: 5/26/2023 3:09 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically prepared cos	•		Date: 5/26/202	23 Time: 3:09 pm
use only	2. [] Manually prepared cost repo				
	3. [0] If this is an amended report 4. [F] Medicare Utilization. Enter				ost report
Contractor use only	(1) As Submitted 7. Con (2) Settled without Audit 8. [N	e Received: htractor No.]]nitial Report fo]]Final Report for	11. pr this Provider CCN12.		or Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERT	FIFICATION BY A CHIEF FINANCIAL OFFI	I CER OR ADMINISTRATO	OR OR PROVIDER(S)		
ADMI NI STRATI VE PROVI DED OR PF	FION OR FALSIFICATION OF ANY INFORMA E ACTION, FINE AND/OR IMPRISONMENT U ROCURED THROUGH THE PAYMENT DIRECTLY E ACTION, FINES AND/OR IMPRISONMENT	JNDER FEDERAL LAW. Y OR INDIRECTLY OF A	FURTHERMORE, IF SERVIC	ES IDENTIFIED IN T	HIS REPORT WERE
CERTI	FICATION BY CHIEF FINANCIAL OFFICER	OR ADMI NI STRATOR Of	f PROVIDER(S)		
electi Stater period	EBY CERTIFY that I have read the abor ronically filed or manually submitte ment of Revenue and Expenses prepare d beginning 01/01/2022 and ending 12 ment are true, correct, complete and	ed cost report and s ed by PARKVIEW WABAS 2/31/2022 and to the	submitted cost report a SH HOSPITAL, INC. (15- e best of my knowledge	nd the Balance She 1310) for the cos and belief, this r	et and t reporting eport and

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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jean	ne Wickens	т	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
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	327, 120	-859, 893	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	8, 268	0		0	5.00
6.00 SWING BED - NF		0				0	6.00
10.00 RURAL HEALTH CLINIC I		0		0		0	10.00
10.01 RURAL HEALTH CLINIC II		0		58, 230		0	10.01
10.02 RURAL HEALTH CLINIC II	I	0		124, 738		0	10.02
200. 00 TOTAL		0	335, 388	-676, 925	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	PARKVI EW WABASH H I DENTI FI CATI ON DATA			N: 15-1310	Period: From 01/01/ To 12/31/	/2022		et S-2 me Pre	2 epared:
	1.00	2.00		3.00			4.00	5/26/20)23 3:0	09 pm
	Hospital and Hospital Health Care Co			5.00			4.00			
	Street: 10 JOHN KISSINGER DR	PO Box:								1.00
. 00	City: WABASH	State: IN Component Name	Zip Cod CCN	e: 4699 CBS		nty: WABASH er Date	Dovim	ent Syst	om (D	2.00
		component Name	Number	Numb				, 0, or		
					- J.		V	XVIII	XIX	
		1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
. 00	Hospital and Hospital-Based Componer Hospital	PARKVIEW WABASH	151310	9997	15 1	12/17/2001	N	0	Р	3.00
. 00		HOSPITAL, INC.	151510	777		12/1//2001				3.00
. 00 . 00 . 00 . 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	PARKVI EW WABASH	15Z310	999	15	12/17/2001	N	0	N	4.00 5.00 6.00 7.00
00 00	Swing Beds - NF Hospital-Based SNF	HOSPI TAL SWING BEDS	102010							8.00 9.00
 00 	Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC									10.00 11.00 12.00 13.00 14.00 15.00
5. 01	Hospital -Based Health Clinic - RHC	RURAL HEALTH CLINIC -	158541	9997	15	06/05/2019	N	N	N	15.01
	111	N.MANCHESTER RURAL HEALTH CLINIC - KISSINGER	158542	9997	15	07/24/2019	N	N	N	15.02
7.00 3.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other									16.00 17.00 18.00 19.00
						From:		То		_
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1.00 01/01/2 2		2.0		20.00
				ŀ	1.00	2.00)	3. ()0	-
	Inpatient PPS Information									
. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am	ith 42 CF this		Ν	N				22.00
	Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c	column 1, "Y" for yes g period occurring prio "N" for no for the por	or "N" fo r to Octo tion of t	r no ber	Ν	Ν				22.01
	instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th	? (see instructions) En e portion of the cost r	ter in co eporting		Ν	N				22.02
03	period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph 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 reporting period occurring on or aft	g period on or after Oc ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t	tober 1. m urban t istical a "N" for er 1. Ent he cost	o reas no	Ν	N		N		22.03
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	100 but not more than 4 2.105)? Enter in column ic reclassification fro delineations for stati column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst	99 beds (3, "Y" f m urban t stical ar r "N" for er 1. Ent he cost ructions)	or o eas no er						22.04
. 00	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens of identifying the days method used in the prio	n 3, "Y" and/or 2 us days, in this r cost	for 5 or 3		2 N				23.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	N: 15-1310	Peri od:	1 (0000	Worksh	eet S-2	2
				From 01/0 To 12/3	1/2022	Part I Date/T 5/26/2		
	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	Medicai HMO day	d O /s Mea	ither di cai d days	
	1.00	2.00	3.00	4.00	5.00		5.00	
 .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. .00 If this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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 3, out-of-state Medicaid eligible unpaid 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. 	0	0		0		0	С	24.
		L	1	Urban/R	lural S			
			al and the C	1.(2.	00	01
 .00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for .00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or 	rural. ge) status "2" for r	at the en rural. If a	d of the co		2 2			26.0
enter the effective date of the geographic reclassifi .00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	О			35.0
				Begi ni 1. (Endi 2.		
 .00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date .00 If this is a Medicare dependent hospital (MDH), enter 	S.				o			36.
is in effect in the cost reporting period. .01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	e MDH trar	nsitional p	ayment in					37.
instructions) 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.
2.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? En e requireme	ter in colu nts in	Imn	00	<u>Y/</u> 2. (N	00	39.
.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.	er 1. Ente	er "Y" for				N XVIII		40.
					1.00		3.00	
Prospective Payment System (PPS)-Capital .00 Does this facility qualify and receive Capital paymen	t for dier	roportiona	to sharo in	accordance	e N	N	N	45.
with 42 CFR Section §412.320? (see instructions) .00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption for	extraordi n	ary circums	tances	N	N	N	46.
Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PPS c .00 Is the facility electing full federal capital payment			5		N N	N N	N N	47. 48.
Teaching Hospitals 1 S 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 27, 2020, Jumn 1 is ms in the	or "N" fo under 42 "Y", or if prior year	r no in col CFR 413.78(this hospi or penulti	umn 1. For b)(2), see tal was mate year,	N			56.
"Y" for yes; otherwise, enter "N" for no in column 2. OO For cost reporting periods beginning prior to Decembe 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 c "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	residents column 1. ost report Worksheet applicable 413.77(e	in approve If column ing period E-4. If c For cost)(1)(iv) a	d GME progr 1 is "Y", ? Enter "Y olumn 2 is reporting nd (v), reg	ams trained did "" for yes c "N", periods pardless of	or			57.

		HOSPITAL, INC.		In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC		eriod: rom 01/01/2022	Worksheet S-2 Part I	
				0 12/31/2022	Date/Time Pre 5/26/2023 3:0	pared:
				V	XVIII XIX	7 pili
58.00 If line 56 is yes, did this facility elect cost reim	hurcomo	nt for physici	and convious	1.00	2.00 3.00	58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	compl e	te Wkst. D-5.		as		
59.00 Are costs claimed on line 100 of Worksheet A? If ye	es, comp	lete Wkst. D-2	2, Pt. I. NAHE 413.85	N Worksheet A	Pass-Through	59.00
			Y/N	Li ne #	Qual i fi cati on	
					Cri teri on Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413			N			60.00
instructions) Enter "Y" for yes or "N" for no in co						
is "Y", are you impacted by CR 11642 (or subsequent adjustment? Enter "Y" for yes or "N" for no in colu		E MA payment				
adjustment? Enter y for yes of N for no fin cord	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	2.00	4.00	F 00	
61.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	5.00	61.00
section 5503? Enter "Y" for yes or "N" for no in						
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care						61.01
FTEs from the hospital's 3 most recent cost reports						
ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care	÷					61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						
ACA). (see instructions)						(1 00
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.03
determining compliance with the 75% test. (see						
instructions) 61.04 Enter the number of unweighted primary care/or						61.04
surgery allopathic and/or osteopathic FTEs in the						
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary						61.05
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)	2					
61.06 Enter the amount of ACA §5503 award that is being						61.06
used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	Pro	ogram Name	Program Code	Unweighted	Unweighted Direct GME	
				IME FTE Count	FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0.00	61.10
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. 61.20 Of the FTEs in line 61.05, specify each expanded				0.00	0. 00	61.20
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,	1					
the direct GME FTE unweighted count. Enter Th cordina 4,						
					1.00	
ACA Provisions Affecting the Health Resources and Se	ervi ces	Administration	n (HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trai ne	d in this cost	reporting per	iod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from	a Teach	ing Health Cen		your hospital	0.00	62.01
during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid			ns)			
63.00 Has your facility trained residents in nonprovider s	etti ngs	during this c			N	63.00
"Y" for yes or "N" for no in column 1. If yes, compl	ete lin	es 64 through	67. (see instr	ructions)		

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMP		WABASH HOSPITAL, INC. ATA Provider C		eriod:	Worksheet S-2	2
				Fr To	rom 01/01/2022 0 12/31/2022	Part I Date/Time Pre 5/26/2023 3:0	
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea	nr FTE Residents in N	Nonprovider Settings-				
	period that begins on or after J						
. 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	on-primary care n all nonprovider ed non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTËs Nonprovi der	FTEs in Hospital	3/ (col . 3 + col . 4))	
				Site			-
5.00	Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	65 0
	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	Unweighted	Ratio (col.	
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
	Soction 5504 of the ACA Comment	Voar ETE Docidante :	n Nonnrovi don Cotti-	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsErrective r	or cost report	ing periods	
o. 00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima ccurring in all nonp unweighted non-prima	provider settings. ary care resident	0.00	0. 00	0. 000000	66.0
	(column 1 divided by (column 1 +						
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
				FTES	FTEs in	3/ (col. 3 +	
				Nonprovider Site	Hospi tal	col. 4))	
		1.00	2.00	3.00	4.00	5.00	1
. 00	Enter in column 1, the program		2.00	0.00			67.(
	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						

Health Financial Systems PARKVIEW WABASH HOSPI	TAL, INC.		١r	Lieu	of Form	CMS-2	2552-10
	Provider CCN	F	eriod: rom 01/01/ o 12/31/		Workshee Part I Date/Tir 5/26/202	ne Pre	pared:
		I			1.00		<u>, bui</u>
68.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 F 68.00 For a cost reporting period beginning prior to October 1, 2022, MAC to apply the new DGME formula in accordance with the FY 202 (August 10, 2022)?	did you ob	tain permissi	on from yo		N		68.00
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or do	os it contai	in an IDE suk	provi dor?	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 train 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 d (see instructions)	GME teaching "Y" for yes residents i "Y" for yes	g program in s or "N" for in a new teac s or "N" for	the most no. (see ching no.	N		0	71.00
Inpatient Rehabilitation Facility PPS75.00Is this facility an Inpatient Rehabilitation Facility (IRF), or	does it co	ntain 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, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(ii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting period. 	004? Enter ng program i lumn 3: lf d	"Y" for yes o in accordance column 2 is Y	or "N" for e with 42 ',			0	76.00
					1.00	<u>с</u>	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an	d "N" for n	<u>ר</u>			N		80.00
81.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers) period? E	Inter	N		81.00
 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 86.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 	no.	N		85.00 86.00			
87.00 Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	lassified u	nder section			Ν		87.00
			Approved Permane Adjustme (Y/N) 1.00	ent ent	Number Approv Perman Adjustm 2.00	ved lent lents	
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)							88.00
Column 2: Enter the number of approved permanent adjustments.		Wkst. A Line No.	Effecti Date		Approv Perman Adjustr Amount	nent ment Per	
	_	1.00	2.00		Di scha 3. 00	-	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line on which the per discharge permanent adjustment approval was ba Column 2: Enter the effective date (i.e., the cost reporting pe beginning date) for the permanent adjustment to the TEFRA targe per discharge. Column 3: Enter the amount of the approved permanent adjustment	sed. riod t amount	0.00				0	89.00
TEFRA target amount per discharge.			V		XIX		
Title V and XIX Services			1.00		2.00	<u>C</u>	
90.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	ervi ces? En	ter "Y" for	N		Y		90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica		either in	N		Ν		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cati (on)? (see			Ν		92.00
93.00 Does this facility operate an ICF/IID facility for purposes of "N" for year of the applicable of the sector		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, and	"N" for no	in the	N		Ν		94.00
 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applic 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. 			0.00 N		0. 00 N	D	95.00 96.00
97.00 fline 96 is "Y", enter the reduction percentage in the applic	able column		0.00		0.00	D	97.00

ealth Financial Systems PARKVIEW WABASH H IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period:	u of Form CM Worksheet S	
			rom 01/01/2022 o 12/31/2022		ronaro
				5/26/2023 3	
			V	XIX	_
8.00 Does title V or XIX follow Medicare (title XVIII) for the ir	torne and ro	cidente post	1.00 N	2.00 N	98.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			N	N IN	90.
18.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.			N	Y	98.
18.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of the costs of Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of the costs of the cos			Ν	Y	98.
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye	ical access l es or "N" for	hospital (CAH) no in column	N	Ν	98.
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XV			Ν	Ν	98.
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98.
<pre>column 2 for title XIX. 88.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.</pre>			N	Y	98.
Rural Providers					
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive me	thod of paymen	t N		105. 106.
07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do	n 1. (see ins you train I&l	structions) Rs in an	N		107.
approved medical education program in the CAH's excluded IF Enter "Y" for yes or "N" for no in column 2. (see instructi 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ons)	.,	N		108.
CIR Section 9412. HS(C). Litter i foi yes on in foi no.	Physi cal	Occupati onal	Speech	Respi rator	v
	1.00	2.00	3.00	4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospita	al Demonstrati	ion project (§	410A	1.00	110.
Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	r "N" for no.	f yes,		
			1.00	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in t	he Frontier (Community	1.00 N	2.00	111.
Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting Dumn 1 is Y, rticipating in	period? Enter enter the n column 2.			
		1.00	2.00	2.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Heal	th Model	1.00 N	2.00	3.00	112.
(PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea	eporting Dumn 1 is Dating in the				
participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.					113.
Miscellaneous Cost Reporting Information		1	1		
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "S for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 93" percent (includes	N			0115.
the definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
	anco? Entor	Y			117.
 17.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence pol 					118.

alth Financial Systems PARKVIEW WABASH H SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	F	eriod: rom 01/01/2022 o 12/31/2022		5-2 Preparec
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:		56, 105			0118.0
			1.00	2.00	_
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			N		118.0
9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient	N	N	119. 120.
1.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntabl e devi ce	s charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1			Ν		122. (
<pre>the Worksheet A line number where these taxes are included. 3.00Did the facility and/or its subproviders (if applicable) pur services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organizati for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from located in a CBSA outside of the main hospital CBSA? In colu "N" for no.</pre>	ing, payroll, on? In column greater than unrelated org	and/or 1, enter "Y" 50% of total anizations			123.
Certified Transplant Center Information 5.00Does this facility operate a Medicare-certified transplant c	ontor? Entor	"V" for yor	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/y 6.00 If this is a Medicare-certified kidney transplant program, e	yyy) below. nter the cert	5			125.
in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare-certified heart transplant program, er in column 1 and termination date, if applicable, in column 2	ter the certi	fication date			127.
8.00 f this is a Medicare-certified liver transplant program, er in column 1 and termination date, if applicable, in column 2	ter the certi	fication date			128.
9.00 If this is a Medicare-certified lung transplant program, ent in column 1 and termination date, if applicable, in column 2					129.
0.00 If this is a Medicare-certified pancreas transplant program, date in column 1 and termination date, if applicable, in col 1.00 If this is a Medicare-certified intestinal transplant progra	umn 2. m, enter the				130. 131.
date in column 1 and termination date, if applicable, in col 2.00 If this is a Medicare-certified islet transplant program, er in column 1 and termination date, if applicable, in column 2	ter the certi	fication date			132.
 3. 00 Removed and reserved 4. 00 If this is a hospital-based organ procurement organization (in column 1 and termination date, if applicable, in column 2 All Depuiders 		he OPO number			133. 134.
All Providers 0.00 Are there any related organization or home office costs as c chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number. 1.00 2.00	yes, and home (see instruc	office costs	Y 3.00	15H032	140.
If this facility is part of a chain organization, enter on I	ines 141 thro	ough 143 the na		of the home	•
office and enter the home office contractor name and contract 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WIS SER		I ANS Contractor	r's Number: 0810)1	141.
2.00 Street: 10501 CORPORATE DRIVE PO Box: 560				-	142.
3. OO City: FORT WAYNE State: IN		Zip Code:	4684	15	143.
	2			1.00	
4.00 Are provider based physicians' costs included in Worksheet A	?			Y	144.
			1.00	2.00	
5.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	column 1. If	column 1 is			145.
6.00Has the cost allocation methodology changed from the previou Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1			N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	. Pro	vider CC	:N: 15-1310	F		/01/2022	Worksheet S- Part I	
					T	o 12/	′31/2022	Date/Time Pr 5/26/2023 3:	
								1.00	_
47.00 Was there a change in the statist	cal basis? Enter "Y"	for yes or	"N" for	no.				N	147.00
48.00 Was there a change in the order o	f allocation? Enter "Y	(" for yes	or "N" fe	or no.				Ν	148.00
49.00 Was there a change to the simplif	ed cost finding metho							N	149.00
			rt A	Part			tle V	Title XIX	-
Does this facility contain a prov	idor that qualifies fo		.00	2.00		-	. 00 the Low	4.00	
or charges? Enter "Y" for yes or									
55. 00 Hospi tal			N	N	5. (N	N	155.0
56.00 Subprovi der – IPF			N	N			Ν	Ν	156.0
57.00 Subprovi der – IRF			N	N			Ν	Ν	157.0
58. 00 SUBPROVI DER									158.0
N N N								N	159.0
60.00HOME HEALTH AGENCY 61.00CMHC			N	N			N N	N	160.0
				IN			IN	IN	161.0
								1.00	-
Multicampus									
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or m	ore camp	uses in d	i ffer	ent CBS	SAs?	Ν	165.0
Enter f for yes of in for no.	Name	Cour	itv	State	7i n	Code	CBSA	FTE/Campus	
	0	1. (2.00		00	4.00	5.00	-
66.00 fline 165 is yes, for each								0.0	0166.00
campus enter the name in column									
0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in column 5 (see instructions)									
	_							1.00	
Heal th Information Technology (HI	T) incentive in the Am	merican Rec	overy an	d Reinves	tment	t Act		Y	
67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1						ontor	tho	Y	167.00
reasonable cost incurred for the				0/15	т),	enter	the		100.0
68.01 If this provider is a CAH and is			provi de	r qualifv	for	a hards	shi p		168.0
exception under §413.70(a)(6)(ii)									
69.00 If this provider is a meaningful		and is no	t a CAH	(line 105	is "	N"), er	nter the	0. C	0169.0
transition factor. (see instructi	ons)								
							nni ng	Ending	-
70.00 Enter in columns 1 and 2 the EHR	oginning date and ond	ling dato f	or the r	oporting			. 00	2.00	170.0
period respectively (mm/dd/yyyy)	begi nini ng date and end	ang uate i	or the r	eportring					170.00
								0.00	_
	ildor havo any dave fo	ar individu	ale opro	llodin			. 00 N	2.00	0171.0
		11 I I I I I VI (111				1	IN		U1/1.00
71.00 If line 167 is "Y", does this pro					er				
section 1876 Medicare cost plans "Y" for yes and "N" for no in col	reported on Wkst. S-3,	Pt. I, li	ne 2, co	I. 6? Ent					

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1310	Period: From 01/01/2022	Worksheet S-	2
				To 12/31/2022	Date/Time Pr	epared
				Y/N	5/26/2023 3: Date	<u>09 pm</u>
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS					
	General Instruction: Enter Y for all YES responses. Enter	N for all NO r	esponses. Ente	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to th	e beainnina of	the cost	N		1 1.0
	reporting period? If yes, enter the date of the change in					
			Y/N	Date	V/I	
	<u> </u>		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		N			2.0
	voluntary or "I" for involuntary.	IIII 5, V 101				
. 00	Is the provider involved in business transactions, includi	ng management	N			3.0
	contracts, with individuals or entities (e.g., chain home					
	or medical supply companies) that are related to the provi	der or its				
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and oth	er similar				
	relationships? (see instructions)	-	Y/N	Туре	Date	_
			1.00	2.00	3.00	
	Financial Data and Reports		1.00	2.00	0.00	
. 00	Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A		4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.0
	Those on the fired financial statements? If yes, submit re			Y/N	Legal Oper.	
				1.00	2.00	+
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provider	• N		6.0
	the legal operator of the program?					
. 00	Are costs claimed for Allied Health Programs? If "Y" see i			N		7.0
. 00	Were nursing programs and/or allied health programs approv	ed and/or rene	wed during the	e N		8.0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medi	cal education	Ν		9.0
00	program in the current cost report? If yes, see instructio			IN		7.0
0. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.0
	cost reporting period? If yes, see instructions.					
1.00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1.00	-
	Is the provider seeking reimbursement for bad debts? If ye	s see instruc	tions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection			st reportina	N	13.0
	period? If yes, submit copy.	p=::==================================				
	If line 12 is yes, were patient deductibles and/or coinsur	ance amounts w	aived? If yes,	see	N	14.0
4.00	instructions.					_
4.00					Y	
	Bed Complement	ing pariod2 lf	was see inst	ructionc	Ť	1 1 5 0
					rt B	15.0
	Bed Complement	Par	T A	Par	rt B Date	15. C
	Bed Complement				rt B Date 4.00	15.0
5.00	Bed Complement Did total beds available change from the prior cost report PS&R Data	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	Date 4.00	
5.00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only?	Par Y/N	t A Date	Par Y/N	Date	
5.00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	Date 4.00	
5.00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	Date 4.00	
5. 00 5. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Par Y/N 1.00 Y	t A Date 2.00	Par Y/N 3.00 Y	Date 4.00	16. (
5. 00 5. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	Date 4.00	16.0
5. 00 5. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Par Y/N 1.00 Y	t A Date 2.00	Par Y/N 3.00 Y	Date 4.00	16.0
5. 00 5. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Par Y/N 1.00 Y	t A Date 2.00	Par Y/N 3.00 Y	Date 4.00	16.0
5. 00 5. 00 7. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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	Par Y/N 1.00 Y	t A Date 2.00	Par Y/N 3.00 Y	Date 4.00	16.0
5. 00 6. 00 7. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Par Y/N 1.00 Y N	t A Date 2.00	Par Y/N 3.00 Y N	Date 4.00	16.0
5. 00 5. 00 7. 00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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	Par Y/N 1.00 Y N	t A Date 2.00	Par Y/N 3.00 Y N	Date 4.00	16.0
5.00 6.00 7.00 8.00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Par Y/N 1.00 Y N N	t A Date 2.00	Par Y/N 3.00 Y N N	Date 4.00	16. C
5.00 6.00 7.00 8.00	Bed Complement Did total beds available change from the prior cost report PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 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) 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	Par Y/N 1.00 Y N	t A Date 2.00	Par Y/N 3.00 Y N	Date 4.00	16. C

Health Financial Systems

PARKVIEW WABASH HOSPITAL, INC.

In Lieu of Form CMS-2552-10

Health	Financial Systems PARKVIEW WABASH	HUSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/26/2023 3:0	pared:
		Descri	ption	Y/N	Y/N	- P
		(2	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	lfyes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th	ne cost reportin	ng period? If	yes, submit	Ν	27.00
	copy. Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service Re	serve Fund)	Ν	29.00
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	Ν	30.00
	instructions.					
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? IT yes,	see	Ν	31.00
	Purchased Services	C			N	
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	N	33.00
	Provi der-Based Physi ci ans					1
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-ba	sed physi ci ans?	Y Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	Ν	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Y		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lfyes, see	N		40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SHANNON		ECENBARGER		41.00
42.00	respectively. Enter the employer/company name of the cost report	PARKVI EW HEALT	H SYSTEM, INC.			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	N/A		SHANNON. ECENBA	RGER@PARKVI EW.	43.00

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE	Provider CCN: 15-1310	Period:	Worksheet S-2	
			From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	nared
			10 12/01/2022	5/26/2023 3:0	<u>9 pm</u>
		3.00			
Cost Report Preparer Contact Informatic	on				
41.00 Enter the first name, last name and the		REI MBURSEMENT DI RECTOR			41.00
held by the cost report preparer in co	lumns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the	cost report				42.00
preparer.					
43.00 Enter the telephone number and email a	ddress of the cost				43.00
report preparer in columns 1 and 2, re	specti vel y.				

USPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/26/2023 3:00	pared:
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		Line No.	Nor or bodo	Avai I abl e	or all filled to		
		1.00	2.00	3.00	4.00	5.00	
	PART I – STATISTICAL DATA	1			-		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00	18	6, 5	70 72, 024. 00	0	1.00
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.00
. 00	HMO IPF Subprovider						3.00
. 00	HMO I RF Subprovider						4.00
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
. 00	Hospital Adults & Peds. Swing Bed NF		10	(0	6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		18	6, 5	70 72, 024. 00	0	7.00
. 00	INTENSIVE CARE UNIT						8.00
. 00	CORONARY CARE UNI T						9.0
0.00	BURN I NTENSI VE CARE UNI T						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY	43.00				0	13.0
4.00	Total (see instructions)		18	6, 5	70 72, 024. 00	0	14.0
5.00	CAH visits					0	15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER – IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23. C 24. C
4.00 4.10	HOSPICE HOSPICE (non-distinct part)	30.00					24.0
5.00	CMHC - CMHC	30.00					24.
6.00	RURAL HEALTH CLINIC	88.00				0	26.0
6.01	RURAL HEALTH CLINIC II	88.01				0	26.0
6.02	RURAL HEALTH CLINIC III	88.02				Ő	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)		18				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambulance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
2.01	Total ancillary labor & delivery room						32.0
2 00	outpatient days (see instructions)						
3.00 3.01	LTCH non-covered days						33.0
	LTCH site neutral days and discharges						33.0

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2022 To 12/31/2022		epare
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	927	58	3, 00	1		1.
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
00	HMO and other (see instructions)	1, 200	315				2.
00	HMO I PF Subprovi der	1, 200	0				3.
)0)0	HMO I RF Subprovi der	0	0				4
00	Hospital Adults & Peds. Swing Bed SNF	31	0	8	0		5
00	Hospital Adults & Peds. Swing Bed SM	51	0	2			6
00	Total Adults and Peds. (exclude observation	958	58	3, 11			7
	beds) (see instructions)	,		0,			<i>'</i>
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGICAL INTENSIVE CARE UNIT						11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY		4	10	8		13
00	Total (see instructions)	958	62	3, 21	8 0.00	198. 17	
00	CAH visits	0	0		0		15
00	SUBPROVIDER - IPF						16
00	SUBPROVIDER - IRF						17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00 00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22
00	HOSPICE						23
10	HOSPICE (non-distinct part)			7	4		24
00	CMHC - CMHC			,			25
00	RURAL HEALTH CLINIC	o	o		0.00	0.00	
01	RURAL HEALTH CLINIC II	2, 170	71	12, 57		15.47	
02	RURAL HEALTH CLINIC III	4, 491	455	43, 17	5 0.00	33.64	26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26
00	Total (sum of lines 14-26)				0.00	247.28	27
00	Observation Bed Days		33	1, 48	0		28
00	Ambulance Trips	0					29
00	Employee discount days (see instruction)			1			30
00	Employee discount days - IRF				0		31
00	Labor & delivery days (see instructions)	0	0	3	-		32
01	Total ancillary labor & delivery room				0		32
00	outpatient days (see instructions)						0
. 00 . 01	LTCH non-covered days LTCH site neutral days and discharges	0					33
	TTTH STTP DEUTRAL days and dischardes	0			1		33

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1310	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/26/2023 3:0	pare
	Full Time Equivalents		Dis	charges		
Component	Nonpaid Workers	Title V	Title XVIII		Total All Patients	
PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	34	48 23	1, 083	1
HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HAD IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			3,	47 118 0 0		2 3 4 5 6 7
beds) (see instructions) 1NTENSIVE CARE UNIT CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHER SPECIAL CARE (SPECIFY) 00 NURSERY 00 Total (see instructions) 00 CAH visits 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF 00 SUBPROVIDER 00 SKILLED NURSING FACILITY 00 NURSING FACILITY 00 NURSING FACILITY 00 OTHER LONG TERM CARE 00 HOME HEALTH AGENCY 00 AMBULATORY SURGICAL CENTER (D. P.) 00 HOSPICE	0. 00	0	3,	48 23	1, 083	8 9 10 11 12 13
 10 HOSPICE (non-distinct part) 00 CMHC - CMHC 00 RURAL HEALTH CLINIC 01 RURAL HEALTH CLINIC II 02 RURAL HEALTH CLINIC III 02 RURAL HEALTH CLINIC III 03 FEDERALLY QUALIFIED HEALTH CENTER 00 Total (sum of lines 14-26) 00 Observation Bed Days 00 Ambulance Trips 00 Employee discount days (see instruction) 00 Employee discount days - IRF 00 Labor & delivery days (see instructions) 01 Total ancillary Labor & delivery room 	0.00 0.00 0.00 0.00 0.00					24 25 26 26 26 26 27 28 29 30 31 32 32
outpatient days (see instructions)00LTCH non-covered days01LTCH site neutral days and discharges00Temporary Expansion COVID-19PHE Acute Care				0 0		33 33 34

Heal th	Financial Systems PA	RKVI EW WABASH	HOSPITAL, INC.		In Li	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-	8
			Component		rom 01/01/202 o 12/31/202		
					RHC II		
					1	. 00	-
	Clinic Address and Identification			-		. 00	
1.00	Street		1	_	1104 N. WAYNE		1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		NORTH MANCHEST	00 FR	2.00	3.00 N 46962	2.00
2.00	Torty, State, 211 Sode, Sounty					10702	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		Award	Date	0 3.00
					00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N		0 10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	f other operat	ion(s) and the	operating			
		Sur	nday	Mor	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08:00	11.00
11.00				00.00	17.00		11.00
				-	1.00	2.00	
	Have you received an approval for an exception is this a consolidated cost report as define				N		12.00 13.00
13.00	30.8? Enter "Y" for yes or "N" for no in col				IN		13.00
	number of providers included in this report.						
	numbers below.			Drovid	er name	CCN	
					00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XI X	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
10.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		0.54				
				inty 00	-		
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wedn	esday	-	ursday	
		to	from 7.00	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		17:00	08: 00	17:00	08: 00	17:00	11.00

Health Financial Systems P.	ARKVI EW WABASH	HOSPITAL, INC.		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1310	Period:	Worksheet S-8	
		Component	CCN: 15-8541	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			_	RHC II		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems PA	ARKVI EW WABASH	HOSPITAL, INC.		In Li	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-	8
			Component		rom 01/01/2022 o 12/31/2022		epared:
						5/26/2023 3:	
					RHC III		
					1	. 00	-
	Clinic Address and Identification	-					
1.00	Street		1		8 JOHN KISSIN		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		WABASH	00		N 46992	2.00
2100	for type of a top 211 obdos obdancy					10772	2100
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		A		3.00
					Award 00	Date 2.00	
	Source of Federal Funds			<u> </u>	00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	O(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
10.00	Door this facility aparate as other than a h	acpital bacad	DUC or EOUC2 E	ntor "V" for	1.00 N	2.00	0 10.00
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic				IN		10.00
	2. (Enter in subscripts of line 11 the type o						
	hours.)						
			iday		nday +o	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	0.00	1.00	0.00	
11.00	CLINIC			08: 00	17: 00	08: 00	11.00
					1.00		
12.00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define				N	(13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Provid	er name	CCN	
					00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N 1.00	V 2.00	XVIII 3.00	XI X 4.00	Total Visits 5.00	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
101.00	GME cost? Enter "Y" for yes or "N" for no in						10100
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty 00	_		
2.00	City, State, ZIP Code, County		WABASH 4.	00			2.00
		Tuesday		esday	Thu	rsday	
		to	from	to	from	to	
	Essility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00
	1020	1	100.00	1	100.00	1.7.00	1

Health Financial Systems PA	ARKVI EW WABASH	HOSPITAL, INC.		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
		Component		From 01/01/2022 To 12/31/2022		
				RHC III		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems PARKVIEW	WABASH HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1310	Peri od:	Worksheet S-1	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	pared:
					5/26/2023 3:0	9 pili
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202	column 3 divided by li	ine 202 columi	ו 8)	0. 278928	1.00
	Medicaid (see instructions for each line)	4				
2.00	Net revenue from Medicaid				2, 369, 690	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 supplemental paymen [.]	ts from Medica	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplementa	al payments from Medicai	id		0	5.00
6.00	Medi cai d charges				14, 449, 550	6.00
7.00	Medicaid cost (line 1 times line 6)				4, 030, 384	7.00
8.00	Difference between net revenue and costs for Medic	aid program (line 7 min	nus sum of lii	nes 2 and 5; if	1, 660, 694	8.00
	< zero then enter zero)		``			
0.00	Children's Health Insurance Program (CHIP) (see in	structions for each lir	ne)		05 407	0.00
9.00	Net revenue from stand-alone CHIP				85, 427	9.00
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				516, 095 143, 953	10. 00 11. 00
12.00	Difference between net revenue and costs for stand	lalone (HLP (line 11 mi	inus lino 0·i	f < zero then	58, 526	12.00
12.00	enter zero)			I < Zero then	50, 520	12.00
	Other state or local government indigent care prog	ram (see instructions 1	for each line`			
13.00	Net revenue from state or local indigent care proc				1, 650, 801	13.00
14.00	Charges for patients covered under state or local				20, 024, 708	14.00
	10)	5 1 5				
15.00	State or local indigent care program cost (line 1	times line 14)			5, 585, 452	15.00
16.00	Difference between net revenue and costs for state	e or local indigent care	e program (lii	ne 15 minus line	3, 934, 651	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for	Medicaid, CHIP and stat	te/local indig	gent care progra	ams (see	
17.00	instructions for each line) Private grants, donations, or endowment income res	stricted to funding cha	rity caro		0	17.00
18.00	Government grants, appropriations or transfers for				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and st			s (sum of lines	5, 653, 871	19.00
	8, 12 and 16)	are and recar that going	our o program		0,000,071	
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
		<u></u>	1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line		2 (17 50	(047.070	2 5 (4 050	20.00
20.00	Charity care charges and uninsured discounts for t (see instructions)	the entire facility	2, 617, 58	6 947, 273	3, 564, 859	20.00
21.00	Cost of patients approved for charity care and uni	nsured discounts (see	730, 11	8 947, 273	1, 677, 391	21 00
21.00	instructions)	iisuled discounts (see	/30,11	0 747,275	1,077,371	21.00
22.00	Payments received from patients for amounts previo	ously written off as		0 0	0	22.00
	charity care			-	_	
23.00	Cost of charity care (line 21 minus line 22)		730, 11	8 947, 273	1, 677, 391	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charg		yond a length	of stay limit	N	24.00
25 00	imposed on patients covered by Medicaid or other i		+	n'a langth of	0	25 00
25.00	If line 24 is yes, enter the charges for patient c stay limit	ays beyond the Indigen	t care program	n s rength or	0	25.00
26.00	Total bad debt expense for the entire hospital com	nlex (see instructions))		3, 443, 458	26.00
20.00	Medicare reimbursable bad debts for the entire hospital com				546, 892	
	Medicare allowable bad debts for the entire hospit				841, 371	
28.00	Non-Medicare bad debt expense (see instructions)		,		2, 602, 087	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare	e bad debt expense (see	instructions)	1, 020, 274	
30.00	Cost of uncompensated care (line 23 column 3 plus				2, 697, 665	
31.00	Total unreimbursed and uncompensated care cost (li	ne 19 plus line 30)			8, 351, 536	31.00

Health Financial Systems PA	RKVIEW WABASH HO	OSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period:	Worksheet A	
				From 01/01/2022 To 12/31/2022	5/26/2023 3:0	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Recl assi fi ed Tri al Bal ance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 CAP REL COSTS-BLDG & FIXT		4, 492, 650				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1 007 004	71,621				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	1, 897, 294 1, 022, 084	4, 673, 916 16, 292, 602			6, 571, 210 17, 249, 341	4.00 5.00
7. 00 00700 OPERATION OF PLANT	303, 244	893, 933			1, 197, 177	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	70, 678				8.00
9. 00 00900 HOUSEKEEPI NG	323, 985	181, 511				9.00
10. 00 01000 DI ETARY	600, 414	388, 745				
11. 00 01100 CAFETERI A	0	0	(11.00
13.00 01300 NURSING ADMINISTRATION	542, 892	6, 972	549, 864	4 0	549, 864	13.00
15.00 01500 PHARMACY	714, 003	145, 118	859, 12 ⁻	1 0	859, 121	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	(0 0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			-	1	1	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 321, 439	765, 772				1
43.00 04300 NURSERY	0	0	(0 104, 939	104, 939	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	947, 162	E22 070	1 471 02	2 0	1 471 022	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	947, 102	523, 870			1, 471, 032 0	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		389, 643		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 205, 296	731, 408	1, 936, 704		1, 936, 704	
60. 00 06000 LABORATORY	1,200,270	2, 243, 524			2, 243, 524	
66.00 06600 PHYSI CAL THERAPY	1, 150, 598	46, 457				
67.00 06700 OCCUPATI ONAL THERAPY	0	0		192, 920		
68.00 06800 SPEECH PATHOLOGY	0	0	(84, 397	84, 397	68.00
69. 00 06900 ELECTROCARDI OLOGY	649, 018	107, 605	756, 623	3 0	756, 623	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 047, 689	1, 047, 689	9 -937, 273	110, 416	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(937, 273		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,035,418	4, 035, 418	3 0	4, 035, 418	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		-	-	88.00
88.01 08801 RURAL HEALTH CLINIC II	172, 711	2, 355, 735 6, 027, 785				1
88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC	623, 750 59, 359	6, 027, 785 6, 211			6, 651, 535 76, 676	1
90. 01 09001 SENI OR CARE	480, 668	81, 903			562, 571	90.00
91. 00 09100 EMERGENCY	975, 667	1, 526, 483			2, 502, 150	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,020,100	2,002,100	5	2,002,100	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES	1, 494	-38, 610	-37, 110	6 0	-37, 116	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		0		0 0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 991, 078	46, 678, 996	60, 670, 074	4 0	60, 670, 074	118.00
NONREI MBURSABLE COST CENTERS		(540	(54		(540	100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	70.057	6, 543			6, 543 574, 654	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 PV WABASH HEALTH CLINC-CASS	79, 957	494, 697		4 O		192.00
192. 02 1920 PV WABASH HEALTH CLINC-CASS 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0				192.01
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0				192.02
194. 00 07950 FI TNESS CENTER	0	0				194.00
194. 01 07951 FOUNDATI ON	o	55, 195	55, 19			194.01
194. 02 07952 NEW DI RECTI ON	0	0	(0 0		194.02
194.03 07953 COMMUNI TY & VOLUNTEER SERVI CES	0	27, 468	27, 468	3 0	27, 468	194.03
194.04 07956 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.04
194.0507955 OCCUPATI ONAL HEALTH	0	0	(0 0		194.05
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 071, 035	47, 262, 899	61, 333, 934	4 0	61, 333, 934	200.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider C	CN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet A Date/Time Pr 5/26/2023 3:	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS		·	•			
00	00100 CAP REL COSTS-BLDG & FIXT	134, 483	3, 209, 374				1.
00	00200 CAP REL COSTS-MVBLE EQUIP	-101, 269	1, 453, 456				2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 571, 210				4.
00	00500 ADMINISTRATIVE & GENERAL	-2, 952, 378	14, 296, 963				5.
	00700 OPERATION OF PLANT	-2, 165	1, 195, 012				7.
00	00800 LAUNDRY & LINEN SERVICE	0	166, 784				8.
00	00900 HOUSEKEEPI NG	0	409, 390				9.
. 00	01000 DI ETARY	-8, 278	99, 268				10.
. 00	01100 CAFETERI A	-324, 461	546, 046				11.
. 00	01300 NURSI NG ADMI NI STRATI ON	0	549, 864				13.
. 00	01500 PHARMACY	-52, 422	806, 699				15
. 00	01600 MEDICAL RECORDS & LIBRARY	0	0				16
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	-391, 945	2, 200, 684				30
	04300 NURSERY	0	104, 939				43
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	1, 471, 032				50
	05100 RECOVERY ROOM	0	0				51
	05200 DELIVERY ROOM & LABOR ROOM	0	389, 643				52
	05300 ANESTHESI OLOGY	0	0				53
	05400 RADI OLOGY-DI AGNOSTI C	-11, 167	1, 925, 537				54
	06000 LABORATORY	0	2, 243, 524				60
	06600 PHYSI CAL THERAPY	0					66
	06700 OCCUPATI ONAL THERAPY	0	192, 920				67
	06800 SPEECH PATHOLOGY	0	84, 397				68
	06900 ELECTROCARDI OLOGY	0	756, 623				69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	110, 416				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72
	07300 DRUGS CHARGED TO PATIENTS	0	4, 035, 418				73
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0					88
	08801 RURAL HEALTH CLINIC II	-978					88
	08802 RURAL HEALTH CLINIC III	-483					88
	09000 CLINIC	0					90
	09001 SENI OR CARE	669					90
	09100 EMERGENCY	-81, 299	2, 420, 851				91
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS						
. 00	09500 AMBULANCE SERVICES	37, 117	1				95
0 05	SPECIAL PURPOSE COST CENTERS	-	-				-
	11300 I NTEREST EXPENSE	0					113
8.00		-3, 754, 576	56, 915, 498				118
0 00	NONREI MBURSABLE COST CENTERS		(510				-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 543				190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0					192
	19201 PV WABASH HEALTH CLINC-CASS	0					192
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0				192
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	0				192
	07950 FI TNESS CENTER	0	0				194
	07951 FOUNDATI ON	0	55, 195				194
	07952 NEW DIRECTION	0					194
4.03	07953 COMMUNITY & VOLUNTEER SERVICES	0	27, 468				194
							194
4.04	07956 OTHER NONREI MBURSABLE COST CENTERS 07955 OCCUPATI ONAL HEALTH	0	0				194

2.00 SPEECH PATHOLOGY	Heal th	Financial Systems	PA	RKVIEW WABASH H	In Lieu of Form CMS-2552-10				
Cost Center Line # Salary Other 2.00 3.00 4.00 5.00 A - Rehab Therapy 67.00 185.433 7.487 1.00 OCUPATIONAL THERAPY 67.00 185.433 7.487 2.00 SPECH PATHOLOGY 68.00 81.122 3.275 2.00 TOTALS 0.00 11.106 0 2.00 2.00 0.01 CLINIC 90.00 11.106 0 1.00 1.00 0.01 CLINIC 11.00 524.508 345.999 1.00 0.02 Salary 1.00 524.508 345.999 1.00 1.00 ADMINISTRATIVE & GENERAL 5.00 3.959.103 0 1.00 1.00 ADMINISTRATIVE & GENERAL 5.00 3.959.103 0 1.00 1.00 E - Depreciation 1.454.881 1.00 1.00 1.454.881 1.00 1.00 CAP REL COSTS-MUBLE EQUIP 2.00 1.454.881 1.00 1.00 1.00 1.00 <td>RECLAS</td> <td>SI FI CATI ONS</td> <td></td> <td></td> <td>Provider C</td> <td>CN: 15-1310</td> <td>From 01/01/2022</td> <td>Date/Time Pu</td> <td>repared:</td>	RECLAS	SI FI CATI ONS			Provider C	CN: 15-1310	From 01/01/2022	Date/Time Pu	repared:
2.00 3.00 4.00 5.00 A - Rehab Therapy 67.00 185.433 7.487 7.487 1.00 OCCUPATIONAL THERAPY 67.00 181.122 3.275 2.00 TOTALS 2.06,555 10,762 2.01 2.01 2.01 B - Clinic Dietician - - - 1.00 2.01 C - Cafeteria - - - 1.00 - - 1.00 CAFETERIA - - 1.00 524,508 345,999 1.00 0 Cafeteria - - - - - - 1.00 CAFETERIA - - - - - - 1.00 1.01 - - - - - - - - 1.00 0 - - - - - - - - - - - - - - - -			Increases						
2.00 3.00 4.00 5.00 A Rehab Therapy. 67.00 185.433 7.487 1.00 2.00 SPEECH PATHOLOGY 68.00 81.122 3.275 2.00 TOTALS 2.00 2.01.762 3.05 1.00 2.01 0.00 CLINIC		Cost Center	Line #	Salary	Other				
1.00 OCCUPATIONAL THÉRAPY 67.00 185,433 7,487 2.00 SPEECH PATHOLOGY 68.00 81,122 3,275 100 CLINIC 266,555 10,762 2.00 8 - CLINIC 11,00 264,555 10,762 9 - OL 11,106		2.00	3.00	4.00	5.00				
2.00 SPEECH PATHOLOGY 68.00 81.122 3.275 2.00 100 Clinic Dietician 266.555 10,762 10,0762 10,0762 1.00 CLINIC 90.00 11,106 0 10,00 10,0762 0.00 Cafeteria 11,106 0 10,00 11,106 0 10,00 0.00 Cafeteria 11,00 524,508 345,999 1.00 1.00 1.00 Cafeteria 11,00 524,508 345,999 1.00 1.00 0.00 Cafeteria 3,959,103 - - 1.00 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 1,454,881 1.00 1.00 1.00 MPL.0EV. CHARGED TO 72.00 937,273 1.00 1.00 2.00 0 1,454,881 1.00 1.00 26,233 2.00 1.00 0.0 PATI ENTS 0 0 937,273 1.00 1.00 1.00 2.00 2.00 2.00 2.82,23 2.00 2.00 2.02,23 2.00		A - Rehab Therapy							
2.00 SPEECH PATHOLOGY 68.00 81.122 3.275 2.00 100 Clinic Dietician 266.555 10,762 10,0762 10,0762 1.00 CLINIC 90.00 11,106 0 10,00 10,0762 0.00 Cafeteria 11,106 0 10,00 11,106 0 10,00 0.00 Cafeteria 11,00 524,508 345,999 1.00 1.00 1.00 Cafeteria 11,00 524,508 345,999 1.00 1.00 0.00 Cafeteria 3,959,103 - - 1.00 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 1,454,881 1.00 1.00 1.00 MPL.0EV. CHARGED TO 72.00 937,273 1.00 1.00 2.00 0 1,454,881 1.00 1.00 26,233 2.00 1.00 0.0 PATI ENTS 0 0 937,273 1.00 1.00 1.00 2.00 2.00 2.00 2.82,23 2.00 2.00 2.02,23 2.00	1.00		67.00	185, 433	7, 487				1.00
TOTALS									2.00
B - Clinic Dietician 90.00 11.106 0 1.00 CLINIC 90.00 11.106 0 1.00 C - Cafeteria 11.00 11.00 0 C - Cafeteria 11.00 524,508 345,999 1.00 D - Salary 100 ADMINISTRATIVE & GENERAL 5.00 3.959,103 0 1.00 ADMINISTRATIVE & GENERAL 5.00 3.959,103 0 1.00 E - Depreciation 1.454,881 1.00 1.00 1.00 1.454,881 1.00 F - Implantable Devices 1.00 937,273 1.00 1.00 1.00 PATIENTS - - 0 937,273 1.00 G - Insurance - 0 28,223 1.00 H - 0B Dept. 6101 - - 0 2.00 2.00 H - 0B Dept. 6101 - - 0 30.884 58,759 2.00 1.00 NURSERY 43.00 89, 114 15,825 1.00 2.00 <td></td> <td></td> <td> +</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>			+						
1.00 CLINIC 90.00 11,106 0 C - Cafeteria 11,106 0 0 0 C.AFETERIA 11.00 524,508 345,999 1.00 D - Salary 0 524,508 345,999 1.00 ADMINISTRATIVE & GENERAL 5.00 3,959,103 0 1.00 E - Depreciation 3,959,103 0 1.00 1.00 F - Implantable Devices 0 1,454,881 1.00 F - Implantable Devices 0 937,273 1.00 ADR REL COSTS-MUBLE EQUIP 2.00 937,273 1.00 ATHENTS 0 937,273 1.00 ATHENTS 0 37,122 2.00 Cool CAP REL COSTS-MUBLE EQUIP 2.00 28,223 2.00 Cool CAP REL COSTS-MUBLE EQUIP 2.00 30,884 58,759 2.00 Loo NURSERY 43.00 89,114 15,825 2.00 2.00 Loo 0 65,145 1.00 1.00 1.00 1.00 Loo NURSERY 43.00 89,114			I	2007000	10/ /02				
C C	1 00		90.00	11 106					1 00
C - Cafeteria 11.00 524, 508 345, 999 1.00 CAFETERIA	1.00								1.00
1.00 CAFETERIA 11.00 524,508 345,999 1.00 0 - Sal ary - </td <td></td> <td>C _ Cafeteria</td> <td></td> <td>11, 100</td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td>		C _ Cafeteria		11, 100	0				-
D Sal ary Sal 524, 508 345, 999 D - <td>1 00</td> <td></td> <td>11 00</td> <td>524 509</td> <td>245 000</td> <td></td> <td></td> <td></td> <td>1 00</td>	1 00		11 00	524 509	245 000				1 00
D - Salary 5.00 3,959,103 0 1.00 ADMI NI STRATI VE & GENERAL 5.00 3,959,103 0 E - Depreciation 1.00 CAP REL COSTS-MUBLE EQUIP 2.00 1.454,881 1.00 INPL. DEV. CHARGED TO 0 1.454,881 1.00 1.00 IMPL. DEV. CHARGED TO 72.00 937,273 G - Insurance 0 937,273 1.00 1.00 2.00 2.8,223 1.00 1.00 CAP REL COSTS-MUBLE EQUIP 2.00 2.02 2.8,223 1.00 2.00 2.02 2.00 2.02 2.00	1.00								1.00
1.00 ADMI NI STRATI VE & GENERAL 5.00 3.959,103 0 1.00 E - Depreciation 1.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 1.454,881 1.00 IMPL. DEV. CHARGED TO 72.00 937,273 PATI ENTS 0 937,273 1.00 6 - Insurance 0 937,273 1.00 1.00 CAP REL COSTS-BLOG & FIXT 1.00 37,122 2.00 2.00 28,223 28,223 2.00 2.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 28,223 2.00 1.00 CAP REL COSTS-BLOG & FIXT 1.00 37,122 2.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 28,223 2.00 1.00 NURSERY 43.00 89,114 15,825 2.00 1.00 DELI VERY ROOM & LABOR ROOM 52.00 330,884 58,759 1.00 1.00 LAUNORY & LINEN SERVICE 8.00 96,106 1.00 1.00 J - N. Manchester RHC Sal ary 1.00 1.1,181,378 0 1.00 RURAL HEA		D. Salami		524, 506	343, 999				-
Image: Constraint of the	1 00		F 00	2 050 102					1 00
E - Depreciation 1.00 1.454,881 1.00 CAP REL_COSTS-MVBLE_EQUIP 2.00 1.454,881 1.00 IMPL. DEV. CHARGED TO 72.00 937,273 PATIENTS	1.00	ADMINISTRATIVE & GENERAL							1.00
1.00 CAP_REL_COSTS-MVBLE_EQUIP 2.00 1,454,881 1.00 F - Implantable Devices 0 1,454,881 1.00 IMPL. DEV. CHARGED TO 72.00 937,273 1.00 PATIENTS - - 0 937,273 G - Insurance - - 0 937,273 G - Insurance - - 0 937,273 G - O 937,273 1.00 28,223 1.00 2.00 0 65,345 2.00 2.00 H - 0B Dept. 6101 - 0 65,345 2.00 1.00 NURSERY 43.00 89,114 15,825 2.00 2.00 2.01 52.00 330,884 58,759 2.00 1.00 LUNDRY & LIABOR ROOM 52.00 30,884 58,759 2.00 1.00 LAUNDRY & LINEN SERVICE 8.00 0 96,106 1.00 J - N. Manchester RHC Sal ary 1.181,378 0 1.00 1.00 VIRAL HEALTH CLINIC II 88.01 1.181,378 0 1.00 K -				3, 959, 103	0				_
Image: second									
F - Implantable Devices 1.00 IMPL. DEV. CHARGED TO 72.00 937,273 PATI ENTS 0 937,273 1.00 G - Insurance 0 937,273 1.00 CAP REL COSTS-BLDG & FIXT 1.00 37,122 2.00 2.00 CAP REL COSTS-BLDG & FIXT 1.00 37,122 2.00 1.00 CAP REL COSTS-BLDG & FIXT 1.00 37,122 2.00 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 28,223 2.00 1.00 NURSERY 43.00 89,114 15,825 2.00 1.00 DELI VERY ROOM & LABOR ROOM 52.00 330,884 58,759 2.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 1.00 RURAL HEALTH CLINIC II 88.01 1.181,378 0 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.181,378 0 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.00 1.00 1.00 1.00 K - Ki ssi nger RHC Sal ary	1.00	CAP REL COSTS-MUBLE EQUIP		+					1.00
1.00 IMPL. DEV. CHARGED TO 72.00 937,273 1.00 PATI ENTS				0	1, 454, 881				
PATI ENTS									_
G - I nsurance 0 937, 273 G - I nsurance 1.00 37, 122 1.00 2.00 CAP REL COSTS-BLDG & FIXT 1.00 37, 122 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 28, 223 2.00 H - OB Dept. 6101 0 65, 345 1.00 NURSERY ROOM 52.00 330, 884 58, 759 I - Laundry 1 1.00 96, 106 2.00 J - N. Manchester RHC Sal ary 1.181, 378 1.00 1.00 1.00 RURAL HEALTH CLINIC II 88.01 1.181, 378 0 K - Ki ssi nger RHC Sal ary 1.00 1.00 1.00 1.00 RURAL HEALTH CLINIC III 88.02 2.728, 528 0	1.00		72.00		937, 273				1.00
G - Insurance 1.00 37,122 1.00 2.00 CAP REL COSTS-BLDG & FIXT 1.00 37,122 2.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 28,223 2.00 H - OB Dept. 6101 0 65,345 1.00 1.00 NURSERY 43.00 89,114 15,825 2.00 2.00		PATI ENTS	↓						
1.00 CAP REL COSTS-BLDG & FIXT 1.00 37, 122 1.00 2.00				0	937, 273				
2.00 CAP REL COSTS - MVBLE EQUIP 2.00 28,223 2.00 2.00 H - 0B Dept. 6101 0 65,345 1.00 1.00 NURSERY 43.00 89,114 15,825 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 330,884 58,759 2.00 1 I - Laundry 1 419,998 74,584 1.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 J - N. Manchester RHC Sal ary 1.181,378 1.00 RURAL HEALTH CLINIC II 88.01 1.181,378 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.00 1.00 RURAL HEALTH CLINIC III 88.02 2,728,528 0 1.00									
H - 0B Dept. 6101 0 65, 345 1.00 NURSERY 43.00 89, 114 15, 825 2.00 DELI VERY ROOM & LABOR ROOM 52.00 330, 884 58, 759 1.00 LAUNDRY LINEN SERVICE 8.00 96, 106 J - N. Manchester RHC Sal ary 1.00 1, 181, 378 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.181, 378 1.00 RURAL HEALTH CLINIC III 88.02 2, 728, 528 0 1.00 1.00 RURAL HEALTH CLINIC III 88.02 2, 728, 528 0 1.00	1.00								1.00
H - OB Dept. 6101 1. 00 NURSERY 43. 00 89, 114 15, 825 1. 00 2. 00 DELIVERY ROOM & LABOR ROOM 52. 00 330, 884 58, 759 2. 00 1 - Laundry 1 419, 998 74, 584 1. 00 1. 00 1. 00 LAUNDRY & LINEN SERVICE 8. 00 96, 106 1. 00 1. 00 1. 00 1. 00 J - N. Manchester RHC Sal ary 1. 181, 378 1. 00 1. 181, 378 1. 00 1. 00 K - Ki ssi nger RHC Sal ary 1. 00 2. 728, 528 0 1. 00 RURAL HEALTH CLINIC III 88. 02 2. 728, 528 0 1. 00	2.00	CAP REL COSTS-MVBLE EQUIP	2.00						2.00
1.00 NURSERY 43.00 89,114 15,825 1.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 330,884 58,759 2.00 1 - Laundry 419,998 74,584 1.00 1.00 1.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 1.00 1.00 J - N. Manchester RHC Sal ary 1.181,378 1.00 1.00 1.181,378 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.181,378 1.00 1.00 RURAL HEALTH CLINIC III 88.02 2,728,528 0 1.00				0	65, 345				
2.00 DELIVERY ROOM & LABOR ROOM 52.00 330,884 58,759 2.00 1 - Laundry 1 - Laundry 1 - Laundry 1.00 1 - Laundry 1.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 J - N. Manchester RHC Sal ary 1.1,181,378 1.00 1.00 K - Ki ssi nger RHC Sal ary 1.1,181,378 0 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.00 1.00		H - OB Dept. 6101							
1.00 LAUNDRY & LI NEN SERVICE 8.00 96,106 1.00 J - N. Manchester RHC Sal ary 1.181,378 1.00 K - Ki ssi nger RHC Sal ary 1.181,378 0 1.00 RURAL HEALTH CLINIC III 88.01 1.181,378 0 X - Ki ssi nger RHC Sal ary 1.00 1.00 1.00 X - Ki ssi nger RHC Sal ary 1.00 1.00	1.00	NURSERY	43.00	89, 114	15, 825				1.00
I - Laundry 419,998 74,584 I - Laundry 1.00 1.00 LAUNDRY & LINEN SERVICE 8.00 96,106 J - N. Manchester RHC Sal ary 1.00 I.00 RURAL HEALTH CLINIC II 88.01 1,181,378 0 K - Ki ssi nger RHC Sal ary 1.00 1.00 1.00 RURAL HEALTH CLINIC III 88.02 2,728,528 0 1.00	2.00	DELIVERY ROOM & LABOR ROOM	52.00	330, 884	58, 759				2.00
I - Laundry 1. 00 LAUNDRY & LINEN SERVICE 8.00 96,106 1.00 J - N. Manchester RHC Salary 0 96,106 1.00 J - N. Manchester RHC Salary 1.181,378 1.00 K - Kissinger RHC Salary 1.181,378 0 K - Kissinger RHC Salary 1.00 RURAL HEALTH CLINIC III 88.02 2,728,528 1.00 2,728,528 0				419, 998	74, 584				
1.00 LAUNDRY & LINEN SERVICE 8.00 96, 106 1.00 J - N. Manchester RHC Sal ary 96, 106 1.00 I.00 RURAL HEALTH CLINIC II 88.01 1, 181, 378 1.00 K - Ki ssi nger RHC Sal ary 1.00 1.181, 378 1.00 RURAL HEALTH CLINIC II 88.02 2, 728, 528 1.00 1.00 2, 728, 528 0 1.00		I - Laundry							
1.00 RURAL HEALTH CLINIC II 88.01 1,181,378 1 1 1.00 K - Kissinger RHC Salary 1,181,378 0 1 1.00 1.00 RURAL HEALTH CLINIC II 88.02 2,728,528 0 1.00	1.00		8,00		96, 106				1.00
J - N. Manchester RHC Salary 1. 00 RURAL HEALTH CLINICII 88.01 1,181,378 0 1.00 RURAL HEALTH CLINICII 88.01 1,181,378 0 K - Kissinger RHC Salary 1.00 1.00 1.00 1.00 I.00 RURAL HEALTH CLINICIII 88.02 2,728,528 1.00 1.00 2,728,528 0 1.00			+						
1.00 RURAL HEALTH CLINICII 88.01 1,181,378 0 1.00 K - Kissinger RHC Salary 1.00 88.02 2,728,528 0 1.00 1.00 RURAL HEALTH CLINICIII 88.02 2,728,528 0 1.00		I - N Manchester RHC Salary	I		707 100				
K - Kissinger RHC Salary 1.00 RURAL HEALTH CLINIC III 88.02 2,728,528 2,728,528	1 00		88.01	1 181 378					1 00
K - Kissinger RHC Salary 1.00 RURAL HEALTH CLINICIII 88.02 2,728,528 1.00 2,728,528 0 1.00	1.00								1.00
1.00 RURAL HEALTH CLINICIII 88.02 2,728,528 1.00		K - Kissinger PHC Salary		1, 101, 370	0				-
	1 00		00 00	2 720 520					1 00
	1.00		00.02						1.00
300. 00 la and Total . The leases 4, 041, 170 2, 464, 450 500. 0	E00 00	Crand Total . Increases			2 094 050				E00.00
	500.00		I	9,091,170	2, 904, 930				1000.00

	Financial Systems	PAI	RKVLEW WABASH H				u of Form CMS-2552-
RECLASS	I FI CATI ONS			Provider (CCN: 15-1310	Peri od: From 01/01/2022 To 12/31/2022	
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref		
	6. 00	7.00	8.00	9.00	10.00		
	A - Rehab Therapy						
1.00	PHYSI CAL THERAPY	66.00	266, 555	10, 762		0	1. (
2.00		0.00	0	0		0	2.0
	TOTALS	T	266, 555	10, 762		7	
	B - Clinic Dietician						
1.00	DI ETARY	10.00	11, 106				1.0
		+	11, 106			1	
	C - Cafeteria		11,100				
	DI ETARY	10.00	524, 508	345, 999			1.0
1.00			524, 508			-	1
	D - Salary		524, 500	343, 777			
	ADMINISTRATIVE & GENERAL	5.00		3, 959, 103			1. (
1.00				3, 959, 103		-	1.0
	E - Depreciation		U	3, 959, 103			
		1 00		4 454 004			
1.00	CAP REL COSTS-BLDG & FLXT			1, 454, 881		9	1. (
			0	1, 454, 881			
	F - Implantable Devices						
	MEDICAL SUPPLIES CHARGED TO	71.00		937, 273			1.0
	PATI ENT						
			0	937, 273			
	G - Insurance					_	
1.00	ADMI NI STRATI VE & GENERAL	5.00		65, 345	1	2	1.0
2.00					1	2	2.0
		T	0	65, 345		7	
	H - OB Dept. 6101						
	ADULTS & PEDIATRICS	30.00	419, 998	74, 584			1.0
2.00							2.0
		+	419, 998	74, 584		1	
	I - Laundry			7 17 00 1			
1.00	HOUSEKEEPING	9.00		96, 106			1.0
1.00				<u>96, 106</u>		-	1
	J - N. Manchester RHC Salary		UU	70, 100			
	RURAL HEALTH CLINIC II	88.01		1, 181, 378			1.0
1.00	KUKAL HEALTH CLINIC II	<u> </u>				-	1.0
ļ	K. Kingsinger DUC Calls		0	1, 181, 378			
	K - Kissinger RHC Salary	00.00		0 700 500			
1.00	RURAL HEALTH CLINIC III	88.02		2,728,528		-	1.(
			0	2, 728, 528		4	
500.00	Grand Total: Decreases		1, 222, 167	10, 853, 959			500.0

Heal th	Financial Systems PA	RKVIEW WABASH	HOSPITAL, INC.			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO		То	od: n 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	T BALANCES						
1.00	Land	1, 518, 481	0		0	0	0	1.00
2.00	Land Improvements	2, 143, 602	0		0	0	0	2.00
3.00	Buildings and Fixtures	24,083,380			0	36, 116	282, 752	3.00
4.00	Building Improvements	4, 150, 859	282, 752		0	282, 752	0	4.00
5.00	Fixed Equipment	3, 459, 738	63, 579		0	63, 579	119, 158	5.00
6.00	Movable Equipment	24, 393, 396	374, 574		0	374, 574	0	6.00
7.00	HIT designated Assets	2, 598, 132	61, 239		0	61, 239	0	7.00
8.00	Subtotal (sum of lines 1-7)	62, 347, 588	818, 260		0	818, 260	401, 910	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	62, 347, 588	818, 260		0	818, 260	401, 910	10.00
		Endi ng	Fully					
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	1, 518, 481	0					1.00
2.00	Land Improvements	2, 143, 602	314, 699					2.00
3.00	Buildings and Fixtures	23, 836, 744	12, 521, 286					3.00
4.00	Building Improvements	4, 433, 611	3, 809, 797					4.00
5.00	Fixed Equipment	3, 404, 159	1, 472, 620					5.00
6.00	Movable Equipment	24, 767, 970	14, 675, 393					6.00
7.00	HIT designated Assets	2, 659, 371	1, 443, 626					7.00
8.00	Subtotal (sum of lines 1-7)	62, 763, 938	34, 237, 421					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	62, 763, 938	34, 237, 421					10.00

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2022 Fo 12/31/2022	Worksheet A-7 Part II Date/Time Pre 5/26/2023 3:0	pared:	
			SL	IMMARY OF CAPI	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	WN 2, LINES 1 a	and 2	-			
1.00	CAP REL COSTS-BLDG & FIXT	3, 560, 082			9 0	84, 677	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	71, 621		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	3, 560, 082		707, 26	9 0	84, 677	3.00	
		SUMMARY O	F CAPI TAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at						
		ed Costs (see	9 through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI						
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 492, 650				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	71, 621				2.00	
3.00	Total (sum of lines 1-2)	0	4, 564, 271				3.00	

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Prep 5/26/2023 3:09	pared:
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	0.00	col . 2)	4.00	F 00	
PART III - RECONCILIATION OF CAPITAL COSTS	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	35, 336, 598	0	35, 336, 598	0. 594536	0	1.00
2. 00 CAP REL COSTS-BEDG & TTXT	24, 767, 970				0	2.00
3.00 Total (sum of lines 1-2)	60, 104, 568				0	3.00
		TION OF OTHER (SUMMARY C	F CAPITAL	0100
				001111111111		
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS	-	-			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	2, 239, 684	140, 622	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	1, 353, 612		2.00
3.00 Total (sum of lines 1-2)	0	0	IMMARY OF CAPIT	3, 593, 296	212, 243	3.00
		SU	JWWART OF CAPI I	AL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	111101-001	(see		Capi tal -Rel at		
		instructions)	í í	ed Costs (see		
		, , , , , , , , , , , , , , , , , , ,		instructions)	0,	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS		1	-	1		
1.00 CAP REL COSTS-BLDG & FIXT	707, 269				3, 209, 374	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0				1, 453, 456	2.00
3.00 Total (sum of lines 1-2)	707, 269	65, 345	84,677	0	4, 662, 830	3.00

Health Financial Systems

DJUSTMENTS TO EXPENSES			F	veriod: rom 01/01/2022 o 12/31/2022	Worksheet A-8 Date/Time Pre	
			Expense Classification on To/From Which the Amount is	Worksheet A	5/26/2023 3:0	9 pm
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00		4.00	5.00	1.0
00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00	0	
00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
00 Investment income - other (chapter 2)		0		0.00	0	3.0
00 Trade, quantity, and time		0		0.00	0	4.0
discounts (chapter 8) 00 Refunds and rebates of		0		0.00	0	5.0
expenses (chapter 8) 00 Rental of provider space by		0		0.00	0	6.0
suppliers (chapter 8)		0			0	
stations excluded) (chapter		0		0.00	0	/.0
21) 00 Television and radio service	А	-2, 165	OPERATION OF PLANT	7.00	0	8.0
(chapter 21) 00 Parking lot (chapter 21)		0		0.00	0	9.0
). 00 Provi der-based physi ci an	A-8-2	-506, 130		0.00	0	10.0
adjustment .00 Sale of scrap, waste, etc.		0		0.00	0	11. (
(chapter 23) 2.00 Related organization	A-8-1	309, 814			0	12. (
transactions (chapter 10)		,		0.00	0	
.00 Laundry and linen service .00 Cafeteria-employees and guests	В	-324, 461	CAFETERI A	11.00	0	14.
.00 Rental of quarters to employee and others		0		0.00	0	15.0
b.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.0
patients	2			15.00		
00 Sale of drugs to other than patients	В	-46, 136	PHARMACY	15.00	0	17.
3.00 Sale of medical records and abstracts		0		0.00	0	18.0
.00 Nursing and allied health		0		0.00	0	19.
education (tuition, fees, books, etc.)						
0.00 Vending machines .00 Income from imposition of		0		0.00 0.00	0	
interest, finance or penalty charges (chapter 21)						
2.00 Interest expense on Medicare		0		0.00	0	22.
overpayments and borrowings to repay Medicare overpayments						
.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.
limitation (chapter 14)				((
.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
.00 Utilization review -		0	*** Cost Center Deleted ***	114.00		25.
physicians' compensation		-				
(chapter 21) .00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. (
COSTS-BLDG & FIXT .00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
COSTS-MVBLE EQUIP . 00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.0
. 00 Physicians' assistant		0		0.00	0	29. (
0.00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.0
limitation (chapter 14) 0.99 Hospice (non-distinct) (see			ADULTS & PEDI ATRI CS	30.00		30.9
i nstructi ons)			TUULIS & FLUIAIRIUS	30.00		30.9

Heal th	Financial Systems	PA	RKVIEW WABASH	HOSPITAL, INC.	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1310	Peri od:	Worksheet A-8	;
					From 01/01/2022		
					To 12/31/2022		
					www.Wealesheat	5/26/2023 3:0	19 pm
				Expense Classification of			
				To/From Which the Amount is	s to be Adjusted		
	Cost Contor Deceription	Daoi o (Cada	Amount	Cost Center	line #	Wkst. A-7	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #		
		(2)	2.00	3.00	4,00	Ref. 5.00	
21 00	Additional fragmanical	A-8-3		SPEECH PATHOLOGY	4.00	5.00	31.00
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	08.00		31.00
	pathology costs in excess of						
32.00	limitation (chapter 14)	٨	2, 200	CAD DEL COSTO MURLE FOLLID	2.00	9	32.00
32.00	CAH HIT Adjustment for	A	-3, 399	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
22.00	Depreciation and Interest	D	(20(DUADMACY	15 00	0	22.00
33.00	340B Retail	В		PHARMACY	15.00	0	
33.01	Other Operating Revenue -	В	- 395	ADMINISTRATIVE & GENERAL	5.00	0	33.01
	Admin	P	0.070		10.00	0	
33.02	Other Operating Revenue -	В	-8, 278	DI ETARY	10.00	0	33.02
	Dietary	P	10		F 4 00	0	0.0.00
33.03	Other Operating Revenue -	В	-42	RADI OLOGY-DI AGNOSTI C	54.00	0	33.03
00.04	Radi ol ogy	•	10,000	AD DEL COSTO INVELE FOULD	0.00	0	00.04
33.04	TV Depreciation	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	00.01
33.05	Lobbying	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.00
33.07	Depreciation - Old Hospital	A		CAP REL COSTS-BLDG & FIXT	1.00	9	
33.08	Depreciation - Old Hospital	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	00.00
33.09	PPG Admin Physician Salaries	A		ADMI NI STRATI VE & GENERAL	5.00	0	00.07
33.10	Telemetry Monitoring	А		ADULTS & PEDIATRICS	30.00	0	
33.14	EMS Adjustment	А		AMBULANCE SERVICES	95.00	0	00.11
33.15	HAF Expense Adjustment	A		ADMINISTRATIVE & GENERAL	5.00	0	00110
33.17	Cass RHC	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 18	HeartSmart Scan Reads	A		RADI OLOGY-DI AGNOSTI C	54.00	0	001.10
33. 21	Lobbyi ng	A		RURAL HEALTH CLINIC II	88. 01	0	00.2.
33. 22	Lobbyi ng	A		RURAL HEALTH CLINIC III	88. 02	0	00.22
33.23	SPONSORSHI PS	A		ADMINISTRATIVE & GENERAL	5.00	0	
33.24	COMMUNITY BENEFIT EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00	0	00.21
50.00	TOTAL (sum of lines 1 thru 49)		-3, 754, 576				50.00
	(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.

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

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.	In Lieu of Form CMS-2552-		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1310	Period:	Worksheet A-8	3-1
OFFICE				From 01/01/2022 To 12/31/2022		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					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	ORGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Allocation	12, 269, 618	8, 734, 830	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	Related Party Subsidy (PPG)	0	3, 224, 974	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).			12, 269, 618	11, 959, 804	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas	s not	been	posted to	worksneet A	COLIMINS	and/or 2	, the amou	nt allowable si	noul a be	Indicated in co	Jiumn 4	or this part.	
									Rel ated	Organization(s)	and/or	Home Office	
										3			
			Symbol	(1)		Name		Percentage of		Name	P	ercentage of	
			-					Ownership				Ownershi p	
			1.0	0		2.00		3.00		4.00		5.00	
		B. IN	FERRELATI O	NSHIP TO REL	ATED ORGAN	ZATION(S)	AND/OR HO	ME OFFICE:					

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

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

1 CT IIID GT						
6.00	G	Parkview Health	1.00	Parkview Health	1.00	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	Home Office				100.00
	non-financial) specify:				1	1

(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	PARKVIEW WABASH HOSPI	PARKVIEW WABASH HOSPITAL, INC.				
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANI ZATI ONS AND HOME Pr		From 01/01/2022	Worksheet A-8-1 Date/Time Prepared:		

								5/26/20	23 3:0)9 pm
	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	3, 534, 788	0	1							1.00
2.00	-3, 224, 974	0	r							2.00
3.00	0	0								3.00
4.00	0	0	1							4.00
5.00	309, 814									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

1105 1101	been posted to worksheet A,		Ζ,	the amount	arrowabre	Shourd be	i nui cateu	tin s part.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business								
	5.								
	6.00	1							
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION	S) A	ND/OR HOME	OFFLCE:				

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

	Home Office	6.00						
7.00		7.00						
8. 00 9. 00 10. 00		8.00						
9.00		9.00						
10.00		10.00						
100.00		100.00						

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 WABASH	I HOSPITAL INC		Inlie	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider CCN: 15-1310			Worksheet A- Date/Time Pro 5/26/2023 3:0	8-2 epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	21, 500				7.00	1.00
2.00		ADULTS & PEDIATRICS	404,000			-	-	
3.00		SENIOR CARE	-669				0	
4.00		EMERGENCY	186, 480			-	0	
4.00 5.00	0.00		100, 400	01, 299	105, 181		0	1
	0.00		0	0			0	
6.00	0.00		0	-	-		0	0.00
7.00			0	0			0	
8.00	0.00		0	, i		0	0	8.00
9.00	0.00		0	0		0	0	9.00
10.00	0.00		0	0	105 101	0 0	0	
200.00			611, 311					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	0.00	Education	12	14.00	
1.00	1.00	2.00 ADULTS & PEDIATRICS	8.00	9.00	12.00	13.00 0 0	14.00	1.00
						-		
2.00		ADULTS & PEDIATRICS SENIOR CARE	0	0			-	
3.00			0	-	-	-	0	
4.00		EMERGENCY	0	0			0	
5.00	0.00		0	-	-	0	0	
6.00	0.00		0	0	-	0	0	
7.00	0.00		0	0	C	0	0	
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0		-	0	
10.00	0.00		0	0			0	
200.00			0	0	-	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	15.00					1.00
2.00		ADULTS & PEDIATRICS						2.00
2.00 3.00		SENIOR CARE	0	0				3.00
3.00 4.00		EMERGENCY	0	0				4.00
4.00 5.00	0.00			0				4.00
5.00 6.00	0.00			0	-	, o		6.00
				0		-		7.00
7.00	0.00							
8.00	0.00			0		-		8.00
9.00	0.00			0		-		9.00
10.00	0.00			0	-			10.00
200.00	I	l	0	0	C	506, 130		200.00

ST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1310	Period:	Worksheet B	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pro	
		CAPI TAL REL	ATED COSTS		5/26/2023 3:0	09 pm
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal	
	for Cost			BENEFI TS		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
0 00100 CAP REL COSTS-BLDG & FIXT	3, 209, 374	3, 209, 374				1 1.
0 00200 CAP REL COSTS-MVBLE EQUIP	1, 453, 456		1, 453, 45	56		2.
0 00400 EMPLOYEE BENEFITS DEPARTMENT	6, 571, 210	0		0 6, 571, 210		4.
00 00500 ADMI NI STRATI VE & GENERAL	14, 296, 963	885, 412	400, 98		17, 216, 482	
0 00700 OPERATION OF PLANT	1, 195, 012	367,070			1, 827, 742	
00 00800 LAUNDRY & LINEN SERVICE	166, 784	0		0 0	166, 784	
0 00900 HOUSEKEEPING	409, 390	69, 168		-	616, 105	
00 01000 DI ETARY	99, 268	79, 327	35, 92		235, 766	
00 01100 CAFETERI A	546, 046	141, 611	64, 13		923, 755	
00 01300 NURSI NG ADMI NI STRATI ON	549, 864	6, 096			736, 714	
00 01500 PHARMACY	806, 699	117, 021	52, 99		1, 210, 809	
00 01600 MEDICAL RECORDS & LIBRARY	000,077	0		0 234,075	1, 210, 00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	0		- 0		-
00 03000 ADULTS & PEDIATRICS	2, 200, 684	295, 041	133, 61	623, 406	3, 252, 749	30.
00 04300 NURSERY	104, 939	4, 271	1, 93		140, 361	
ANCILLARY SERVICE COST CENTERS						
00 05000 OPERATING ROOM	1, 471, 032	312, 748	141, 63	37 310, 537	2, 235, 954	50.
00 05100 RECOVERY ROOM	0	0		0 0	() 51.
00 05200 DELIVERY ROOM & LABOR ROOM	389, 643	27, 991	12, 67	76 108, 484	538, 794	1 52.
00 05300 ANESTHESI OLOGY	0	0		0 0	(53.
00 05400 RADI OLOGY-DI AGNOSTI C	1, 925, 537	263, 526	119, 34	45 395, 168	2, 703, 576	54.
00 06000 LABORATORY	2, 243, 524	144, 473	65, 42	29 0	2, 453, 426	60.
00 06600 PHYSI CAL THERAPY	919, 738	11, 777	5, 33	33 289, 842	1, 226, 690) 66.
00 06700 OCCUPATI ONAL THERAPY	192, 920	2, 488	1, 12	27 60, 796	257, 331	67.
00 06800 SPEECH PATHOLOGY	84, 397	1, 078	48	38 26, 597	112, 560	68.
00 06900 ELECTROCARDI OLOGY	756, 623	118, 473	53, 65	54 212, 787	1, 141, 537	69.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	110, 416	0		0 0	110, 416	5 71.
00 07200 IMPL. DEV. CHARGED TO PATIENTS	937, 273	0		0 0	937, 273	3 72.
00 07300 DRUGS CHARGED TO PATIENTS	4, 035, 418	0		0 0	4, 035, 418	3 73.
OUTPATIENT SERVICE COST CENTERS	1		1			
00 08800 RURAL HEALTH CLINIC	0	0		0 0)	
01 08801 RURAL HEALTH CLINIC II	2, 527, 468	0		0 443, 952	2,971,420	
02 08802 RURAL HEALTH CLINIC III	6, 651, 052	0		0 1, 099, 078	7, 750, 130	
00 09000 CLINIC	76, 676	4, 727	2, 14		106, 647	
01 09001 SENI OR CARE	563, 240	88, 284	39, 98		849, 098	
00 09100 EMERGENCY	2, 420, 851	241, 589	109, 41	11 319, 882	3, 091, 733	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART					(92.
		0		0 400	404	05
00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1 1	0		0 490	491	95.
	1					1112
3. 00 11300 INTEREST EXPENSE	E4 015 400	0 100 174			E4 040 744	113.
3. 00 SUBTOTALS (SUM OF LINES 1 through 117)	56, 915, 498	3, 182, 171	1, 441, 13	6, 544, 995	56, 849, 761	1118.
NONREI MBURSABLE COST CENTERS	6, 543	16, 504	7,47	74 0	30, 521	100
2. 00 19200 PHYSICIANS' PRIVATE OFFICES	6, 543 574, 654	10, 304	7,4	0 26, 215	30, 521 600, 869	
. 01 19200 PHYSICIANS PRIVATE OFFICES	574,054	0		0 20, 215		192.
. 02 19201 PV WABASH HEALTH CLINC-CASS	0	0		0 0) 192.
. 03 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0		0 0) 192.
		0		0 0) 192.
. 00 07950 FI TNESS_CENTER . 01 07951 FOUNDATI ON		0 10, 699	1 0.	-		
	55, 195	10, 699	4,84	+5 0	70, 739	
. 02 07952 NEW_DIRECTION . 03 07953 COMMUNITY_&_VOLUNTEER_SERVICES		0		0 0) 194.
	27, 468	0		0 0	27, 468	
1. 04 07956 OTHER NONRELMBURSABLE COST CENTERS		0				194.
1. 05 07955 OCCUPATIONAL HEALTH 0. 00 Cross Foot Adjustments	0	0		0 0) 194.
0.00 Cross Foot Adjustments .00 Negative Cost Centers		~		0 0) 200.) 201.
2.00 TOTAL (sum lines 118 through 201)	57, 579, 358	0 3, 209, 374	1, 453, 45		57, 579, 358	
			1 453 45	101 0 571 7101		ST7117

Cost Center Description ADMINISTRATIV PERAPT LUNRERY 2 PERAPT Distribution 0 Cost Center Description ADMINISTRATIV PERAPT ILLIANRERY 2 NOISE KEEPING DIETARY 0 Control Cost Centers 5.00 7.00 8.00 9.00 10.00 1 DETARY 5.00 7.00 8.00 9.00 10.00 1 DETARY FILE FILE FILE 11.00 DETARY FILE 11.00 0 DETARY ENTRER FILE FILE 11.00 DETARY FILE 11.00 11.00 DETARY FILE 11.00 11.00 FILE FILE 11.00 FILE			ARKVI EW WABASH				u of Form CMS-2	2552-10
LADMIN ISTRATI VI OPERATION OF 5.00 LADMIN ISTRATI VI PLANT LADMIN STRATI VI INSTRATI VI B. 000 DIDETARY 2.00 DODD (AP REL COSTS - LING & FLIXT DODD (AP REL COSTS - MARLE E OUL P DODD (AP RET ION DE PLANT DODD (AP RET ION	COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	1	From 01/01/2022	Date/Time Pre	
GENERAL SERVICE COST CENTERS 1 1.00 00100 (AP REL COSTS ANDLG & FIXT 2.0 2.00 00200 (AP REL COSTS ANDLG & FIXT 2. 3.00 00560 ADMLM STRATIVE & GENERAL 17, 216, 482 5.00 00560 (APRATION OF PLANT 779, 609 2.607, 351 5.00 00560 (APRATION OF PLANT 779, 609 2.607, 351 5.00 00560 (APRATION OF PLANT 779, 609 2.607, 351 5.00 00560 (APRATION OF PLANT 779, 609 2.607, 351 5.00 00560 (APRATION OF PLANT 779, 609 2.607, 351 5.00 001100 (CARFERIA A 394, 020 188, 682 07, 846 011 1.00 01000 (DITARY 516, 461 155, 918 424 60, 197 15 1.00 01500 PLARMACY 516, 461 155, 918 424 60, 197 0 1.00 00000 OPLANTR SERVICE COST CENTERS 9, 870 5, 601 1, 489 2, 197 0 3.00 00000 OPLANTR NO ROM 93, 728 416, 704 29, 326 16, 389		Cost Center Description						
1:00 OTOD CAP FEL COSTS -BUDG & FLXT 1. 0.00 OCAP FEL COSTS -BUDG & FLXT 1. 0.00 OCAP FEL COSTS -BUDG & FLXT 7.00 0.0000 GFMOLOYE BRVEFITS DEPARTMENT 7.70,000 2.37,924 0.00000 GFMOLOYE BRVEFITS DEPARTMENT 7.70,000 2.37,924 5. 0.00000 GLAWREY & LINUS SERVICE 71,140 0.155 0 9.00 0.00000 GUDG DETARY 1.00,564 2.62,703 0 0.00 0 0 1.1000 GUDG DETARY 1.000,000 DETARY 1.000,000 DETARY 0.00,000 0			5.00	7.00	8.00	9.00	10.00	
2:00 00200 CAP REL COSTS AWBLE COULP 2. 0:00 00400 PHAYEE BERKENL 17, 216, 482 2. 0:00 00500 ADM IN STRATI VE & GENRAL 17, 216, 482 5. 0:00 00700 PHATON OF PLANT 779, 600 2. 607, 351 5. 0:00 00700 ADM IN STRATI VE & GENRAL 17, 140 00 237, 924 6. 0:00 00700 ADMSKEP PLANT 170, 040 10. 0. 770, 650 9. 0:00 00700 ADMSKEP PLANT 170, 040 10. 2.7, 924 8. 0:00 00700 ADM INSTRATI VE & GENRAL 17. 14. 0. 7.846 482, 823 11:00 01100 CHEFTEN A 104, 020 18. 6. 0.<					1			
4. 00 00400 [EMPLOYEE ENDERTIS DEPARTMENT 17. 216, 482 5.00 00500 (DECOMUNI STRAT LUE & GENERAL 17. 216, 482 7. 00 00700 (PERATION OF PLANT 779, 609 2. 677, 351 8.00 00800 (DECOMUNI STRAT LUE & GENERAL 17. 216, 482 0. 997, 099 9971, 089 9. 00 00900 (DUSEKEPI NG 222, 795 92, 159 0 971, 089 482, 832 10. 11. 00 01100 (CAFFTERI A 394, 020 188, 682 0 7. 2, 846 0 11. 12. 00 01300 (MENI NG, AMINI STRATI ON 314, 239 81, 12 424 60, 19 0 15. 13. 00 01300 (MENI NG, AMINI STRATI ON 314, 239 81, 12 424 60, 19 16. 14.00 114.00 MENDAL PEROVERS & LIBRARY 50, 611 1, 489 2, 197 40. 30. 00 03000 ADULTS & PEDI ATRIC SC 1, 387, 434 393, 111 66, 57, 12 151, 771 442, 802 65. 0. 00 03000 ADULTS & PEDI ATRIC SC 1, 537, 99, 870 5, 691 1, 489 2, 205 50. 61. 60. 60. 50.								1.00
5. 00 00500 ADM IN STRATI VE & GENERAL. 17, 216, 482 779, 607 78 8. 00 00800 LAUNDRY & LINEN SERVICE 71, 140 0 237, 924 8 9. 00 00900 OUSEKCEPINGS 2627, 795 21, 159 0 971, 059 48, 832 10 10. 00 01000 DIETARY 100, 664 105, 695 0 40, 807 482, 832 10 11. 00 01100 CAFFTERIA 394, 202 188, 662 0 72, 846 0 11 13. 00 01300 AURSI KIE ALL BEARY 0 0 0 0 0 0 0 0 0 0 0 15 16. 00 01300 AURSI KIE ALL RECORDS & LI BRAY 0								2.00
7.00 00700 (DPEANTION OF PLANT 779,600 2.607,351 779,600 2.37,924 78,70 88,600 0.00 00500 (LNINDRY & LINER SERVICE 71,140 237,924 97,1059 9,90 97,059 9,91 00,0100 (LNINDRY & LINER SERVICE 71,140 394,020 188,662 0 72,846 0113 11.00 01100 (CAFETERIA 394,020 188,662 0 72,846 0113 15.00 01500 (PHARMACY 516,461 155,918 424 60,197 0 16 IMPATI ENT ROUTINE SERVICE COST CENTERS 0			17 014 400					4.00
8. 00 000000 LAUNDRY & LINEN SERVICE 71, 140 0 027, 924 8 9. 00 00000 HUSEKEEPING 727, 95 92, 159 971, 059 <td></td> <td></td> <td></td> <td>2 407 251</td> <td></td> <td></td> <td></td> <td>5.00</td>				2 407 251				5.00
9. 00 00900 HULSEKEEPI NG 2262,795 92,159 0 971,059 92 11. 00 01100 CAFETERI A 394,020 188,662 0 72,346 0 13 13. 00 01300 CAFETERI A 394,020 188,662 0 72,346 0 13 15. 00 01500 PHARMACY 516,461 155,918 424 60,197 0						4		8.00
10.00 01000 D1200 D12000 D1200 D12000 D1200 D12000				-				9.00
11.00 01100 CAFETERIA 394.020 188.682 0 72.846 0 13.6 13.00 01300 PHARMACY 516.461 155.918 424 60.197 0								10.00
15. 00 O1500 PHARMACY 516. 461 155. 618 424 60. 70 0					1			11.00
16.00 01500 VECTORAL RECORDS & LIBRARY 0	13.00	01300 NURSI NG ADMI NI STRATI ON					0	13.00
INPATIENT ROUTINE SERVICE COST CENTERS	15.00	01500 PHARMACY	516, 461	155, 918	42	4 60, 197	0	15.00
90. 00 03000 ADULTS & PEDI ATRICS 1, 387, 434 393, 111 65, 712 151, 771 482, 832 30, 430 AND 04300 UNPSERY 59, 870 5, 691 1, 489 2, 197 43, 430 AND 04300 UNPSERY 59, 870 5, 691 1, 489 2, 197 43, 430 AND 04300 UPERATING ROOM 953, 728 0 0 0 0 0 550 51, 00 05000 DELIVERY ROOM & LABOR ROOM 229, 818 37, 294 550 14, 399 0 552 52, 00 05300 ANESTHESI DLOGY 1, 153, 189 37, 294 59 74, 318 0 60 66, 00 06000 LABORATORY 1, 046, 489 192, 495 0 74, 318 0 60 66, 00 06700 OCCUPATIONAL THERAPY 523, 335 1 1, 280 0 68, 00 68, 00 68, 943 157, 852 0 60, 943 0 67, 70 71, 00 0100 DEDI CLA SUPARCED TO PATI ENTS 1, 721, 725 0 0 0 772 73, 90	16.00		0	0	1	0 0	0	16.00
43. 00 [04300] NURSERY 59, 870 5, 691 1, 489 2, 197 0 4 ANCILLARY SERVICE COST CENTERS 59, 870 5, 691 1, 489 2, 197 0 4 50. 00 05000 QPECAUTING ROOM 953, 728 416, 704 29, 326 160, 878 0 55 51.00 05100 RECOVERY ROOM 229, 818 37, 294 5, 510 14, 399 0 53 53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 53 54. 00 05400 RADILOGY-DI AGNOSTIC 1, 153, 189 951, 120 49, 276 135, 560 0 64 60 06600 DEMDRATORY 1, 046, 489 192, 495 0 74, 318 0 66 0 06000 CCUPATIONAL THERAPY 102, 762 3, 315 0 1, 280 66 67 0 0 0 0 0 0 0 0 0 74 318 68 66 68 69 06 69,		INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
ANCILLARY SERVICE COST CENTERS Image: Control of Contrecont								30.00
50:00 05000 0FERATING ROOM 953,728 416,704 29,326 160,878 0 50. 51:00 05000 RECOVERY ROOM 0 0 0 0 0 51. 51:00 05000 RELIVERY ROOM 229,818 37,294 5,510 14,399 0 53. 51:00 05400 RADIOLOGY-DIAGNOSTIC 1,153,189 351,120 49,276 135,560 054. 60:00 06000 PARDENTORY 1,046,489 192,495 0 74,318 0 60. 66:00 06000 PHTNELDEY 523,235 15,691 0 6.058 0 66. 60:00 06000 PECETROCARDI OLOGY 48,013 157,852 0 60.943 0 69. 0100 OTZOOI IMPL, DEV, CHARGED TO PATIENT 1,721,275 0 0 0 0 73. 0107801 RUPL, DEV, CHARGED TO PATIENT 1,721,275 0 0 0 0 73. <td< td=""><td>43.00</td><td></td><td>59, 870</td><td>5, 691</td><td>1, 48</td><td>9 2, 197</td><td>0</td><td>43.00</td></td<>	43.00		59, 870	5, 691	1, 48	9 2, 197	0	43.00
51:00 OS100 RECOVERY ROM O O O O O S1 52:00 OS200 DELVERY ROM & LABOR ROM 229, 818 37, 294 5, 510 14, 399 O S2 54:00 OS400 RADIOLOGY-DIA GROSTIC 1, 153, 189 351, 120 49, 276 135, 560 O S4 00 OS400 RADIOLOGY-DIA GROSTIC 1, 153, 189 351, 120 49, 276 135, 560 O S4 00 OS400 RADIOLOGY-DIA GROSTIC 1, 153, 189 351, 120 49, 276 135, 560 O S4 66:00 O6600 DeGOD CCUPATIONAL THERAPY 523, 235 15, 691 O 6.058 O 66 69:00 O6900 DELCTRCACARDIOLOGY 486, 012 1, 437 O 555 O 68 0 0 0 0 71.0 0 O 0 0 71.1 71.1 73.00 0 0 0 0 72.7 0 0 0 0 73.1 73.00 0 0 0 0 0	E0.00		050 700	447 704	20.00	4/0.070	2	50.00
52:00 052:00 DELIVERY ROM & LABOR ROM 229,818 37,294 5,510 14,399 0 52 53:00 05300 AMESTHESILOGY 0 0 0 0 53 54:00 05400 RADIOLOGY-DIAGNOSTI C 1,153,189 351,120 49,276 135,560 54 60:00 06000 DHYSI CAL THERAPY 522,235 15,691 0 6.058 0 66 60:00 06000 SPECCH PATHOLOGY 48,012 1,437 0 555 0 68 69:00 06900 ELECTROCARDI OLOGY 48,013 157,852 0 60,943 0 67 70:00 07200 IMPL DEV, CHARGED TO PATI ENT 1,721,275 0 0 0 0 73 00 07200 IMPL DEV, CHARGED TO PATI ENTS 1,721,275 0 0 0 0 73 01000 FURGAL ARCHED TO PATI ENTS 1,721,275 0 0 0 0 0 73 0500 OBCOO CLURACE TO PATI ENTS 1,721,275 0 0 0<								50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 55. 54.00 05400 ABORATORY 1, 046, 489 192, 495 0 74, 318 0 60. 66.00 06600 PHYSI CAL THERAPY 523, 235 15, 691 0 6, 058 0 67. 67.00 06700 OCCUPATI ONAL THERAPY 109, 762 3, 315 0 1, 280 0 67. 68.00 068000 ELECTROCARDI OLOGY 486, 012 1, 437 0 555 0 68. 69.00 06900 ELECTROCARDI DLOGY 486, 013 157, 852 0 0 0 73. 0 07300 DRUGS CHARGED TO PATIENTS 1, 721, 275 0 0 0 73. 0 03000 RURAL HEALTH CLINIC C 0			-			-		51.00
54:00 05400 RADIO LOCY-DI AGNOSTI C 1,153,189 351,120 49,276 135,560 0 54.00 60:00 06000 LABORATORY 1,046,489 192,495 0 74,318 0 60. 60:00 06000 PHYSI CAL THERAPY 109,762 3,315 0 1,280 0 66. 60:00 06000 SPECH PATHOLOGY 48,012 1,437 0 555 0 68.0 60:00 0000 SPECH PATHOLOGY 486,913 157,852 0 60.943 0 72.0 71:00 07200 IMPL. DEV. CHARGED TO PATI ENTS 399,786 0 0 0 72. 00 0300 DRUGS CHARGED TO PATI ENTS 1,221,275 0 0 0 0 72. 73:00 0300 RUGS CHARGED TO PATI ENTS 399,786 0 0 0 0 72. 88:01 08800 RURAL HEALTH CLINIC II 1,267,435 0 0 0 0 88. 88.02 88022 RURAL HEALTH CLINIC II 1,267,432 0 0 <td></td> <td></td> <td></td> <td>37, 294</td> <td></td> <td></td> <td></td> <td>52.00</td>				37, 294				52.00
60.00 06000 LABORATORY 1.046, 489 192, 495 0 74, 318 0 60.00 66.00 06000 PHSI CAL THERAPY 523, 325 15, 661 0 60.00 72.00 70.00 00 00 00 72.00 73.00 00.00 00 73.00 00.00 00			-	351 120		-		54.00
66.00 06000 PHSI CAL THERAPY 523, 235 15, 691 0 6,058 0 66.0 67.00 06000 OCCUPATI ONAL THERAPY 109, 762 3, 315 0 1, 280 0 67.00 68.00 06800 SPEECH PATHOLOCY 486, 012 1, 437 0 555 0 68.0 69.00 00 00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>60.00</td>								60.00
67.00 66700 OCCUPATI ONAL THERAPY 109, 762 3,315 0 1,280 0 67. 68.00 06800 SPEECH PATHOLOGY 48,012 1,437 0 555 0 68. 69.00 06900 ELECTROCARDI OLOGY 486,913 157,852 0 00 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 47,097 0 0 0 0 0 0 0 0 0 0 0 0 73. 00107201 MED CAL SUPPLIES CHARGED TO PATIENTS 1,721,275 0 0 0 0 0 0 73. 00107471 ENVICES COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 88. 88.02 0800 R0RAL HEALTH CLINIC III 1,267,435 0 0 0 0 0 88. 89.00 09000 CLINIC 45,489 6,299 0 2,432 0 0 0 0 0 0							° °	66.00
68.00 06800 SPEECH PATHOLOGY 48,012 1,437 0 555 0 68. 69.00 06900 ELECTROCARDIOLOGY 48,013 157,852 0 60,943 0 69. 71.00 07100 MPL. DEV. CHARGED TO PATIENTS 399,786 0 0 0 71. 72.00 07300 PRUSS CHARGED TO PATIENTS 1,721,275 0 0 0 73. 0UTPATIENT SERVICE COST CENTERS 0								67.00
71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 47,097 0 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 399,786 0 0 0 73. 73.00 07300 DRUSC CARAGED TO PATIENTS 1,721,275 0 0 0 0 73. 00 08800 RURAL HEALTH CLINIC 1 1,267,435 0 0 0 88. 88.01 08802 RURAL HEALTH CLINIC III 1,267,435 0 0 0 88. 90.00 09000 CLINIC 45,849 6,299 0 2,432 0 90. 90.01 09010 EMERCENCY 362,176 117,629 0 45,414 90. 92. 92.00 9200 0 0 0 90. 92.00	68.00		48, 012				0	68.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 399,786 O O O O 72.00 73.00 DRUGS CHARGED TO PATIENTS 1,721,275 O O O O 73.00 007300 DRUGS CHARGED TO PATIENTS 1,721,275 O O O 73.00 88.00 08800 RURAL HEALTH CLINIC II 1,267,435 O O 0 88.80 88.01 08802 RURAL HEALTH CLINIC III 3,305,780 O O 0 88.80 90.00 09000 CLINIC 45,489 6,299 2,432 90.90 91.00 09100 ENIGRENCY 1,318,782 86,187 124,275 91.90 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART 72.75 0 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75 91.72.75.75 91.72.75.75 91.72	69.00	06900 ELECTROCARDI OLOGY	486, 913	157, 852		0 60, 943	0	69.00
73.00 07300 DUIDS CHARGED TO PATIENTS 1,721,275 0 0 0 73. 0UTPATIENT SERVICE COST CENTERS	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 097	0		0 0	0	71.00
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.01 88.01 008001 RURAL HEALTH CLINIC III 1, 267, 435 0 0 0 0 88.01 90.00 09000 CLINIC 45, 449 6, 299 0 2, 432 0 90.01 90.01 09001 ENIOR CARE 362, 176 117, 629 0 45, 414 0 90.01 90.01 09010 EMERGENCY 1, 318, 754 321, 892 86, 187 124, 275 0 91. 92.00 09500 ABURSABLE COST CENTERS 92. 95.00 9500 09500 AMBUSABLE COST CENTERS 91. 91.00 011001 INTERST EXPENSE 113.00 INTERST EXPENSE 113.00 INTERST EXPENSE 113.01 100.01 100.01 190.01 190.01 0 0 0 0 192.01 192.01 192.01 92.92.97.066 482,832 118.00 118.00	72.00		399, 786				0	72.00
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 88. 88.01 08801 RURAL HEALTH CLINIC 1 267,435 0 0 0 0 88. 88.02 08802 RURAL HEALTH CLINIC 1 3,305,780 0 0 0 0 88. 90.00 09001 SENIOR CARE 362,176 117,629 0 45,414 0 90. 91.00 09000 BERGENCY 1,318,754 321,892 86,187 124,275 0 91. 92.00 09200 DSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 0 92. 95.00 09500 AMBULANCE SERVICES 209 0 0 0 0 95. 95.00 11300 INTEREST EXPENSE 113.01 113.01 113.01 117. 16,905,279 2,571,106 237,924	73.00		1, 721, 275	0		0 0	0	73.00
88.01 08801 RURAL HEALTH CLINIC II 1, 267, 435 0 0 0 88. 88.02 08802 RURAL HEALTH CLINIC III 3, 305, 780 0 0 0 0 88. 90.00 09000 CLINIC 1 3, 305, 780 0 0 0 0 88. 90.01 09000 CLINIC 45, 449 6, 299 0 45, 414 0 90. 91.00 09000 EMERGENCY 1, 318, 754 321, 892 86, 187 124, 275 0 91. 92.00 09500 AMBULANCE SERVICES 209 0 0 0 0 95. 95.00 09500 AMBULANCE SERVICES 209 0 0 0 95. 9113:00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113. 118. 118. 118. 118. 119.00 192.01 920.0 0 84.90 0 192. 192.00 19200 PHYSICIANS' PRIVATE OFFICES 256, 296 0 0 0 0 192. <	~~ ~~				1			
88.02 08802 RURAL HEALTH CLINIC III 3, 305, 780 0 0 0 0 88. 90.00 09000 CLINIC 45, 489 6, 299 0 2, 432 0 90. 90.01 0901 SENIOR CARE 362, 176 117, 629 0 45, 414 0 90. 91.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 1, 318, 754 321, 892 86, 187 124, 275 0 91. 92.00 09500 ABURASABLE COST CENTERS 209 0 0 0 95. 95.00 09500 ABURACE SERVICES 209 0 0 0 95. 95.01 11300 INTREST EXPENSE subtrotals (SUM OF LINES 1 through 117) 16, 905, 279 2, 571, 106 237, 924 957, 066 482, 831 118. 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 16, 905, 279 2, 571, 106 237, 924 957, 066 482, 831 18. 190.00 I 9200 PIX SCALE SUBTOTALS (SUM OF LINES 1 through 117) 16, 905, 279 2, 571, 106 237, 924 957, 066 192.02 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>88.00</td>			-					88.00
90.00 09000 CLINIC 45,489 6,299 0 2,432 0 90. 90.01 09001 SENIOR CARE 362,176 117,629 0 45,414 0 90. 91.00 DP100 EMERGENCY 1,318,754 321,892 86,187 124,275 0 91. 92.00 OSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 92. 07500 AMBULANCE SERVICES 209 0 0 0 0 95. 95.00 O9500 (AMBULANCE SERVICES 209 0 0 0 0 95. 95.00 O9500 (AMBULANCE SERVICES 209 0 0 0 0 95. 113.00 INTEREST EXPENSE 113. 113. 113. 113. 114.23. 118. 113. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23. 114.23.				-		-		88.01
90. 01 09001 SENI OR CARE 362, 176 117, 629 0 45, 414 0 90. 91. 00 91.00 09100 EMERGENCY 1, 318, 754 321, 892 86, 187 124, 275 0 91. 92. 00 09200 0BES (NON-DI STI NCT PART 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 91. 92. 92. 91. 92. 92. 91. 92. 92. 92. 92. 92. 92. 91. 92. 92. 92. 92. 92. 92. 91. 92. 92. 92. 93. 93. 93. 93. 93. 93. 93. 93. 93. 93. 93. 94. 94. 94. 94. 94. 94. 94. 94. 94. 94. 94. 94. 94.				-		-		•
91.00 09100 EMERGENCY 1, 318, 754 321, 892 86, 187 124, 275 0 91. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.								90.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 209 0 0 0 95. 95.00 09500 AMBULANCE SERVICES 209 0 0 0 95. 95.01 09500 AMBULANCE SERVICES 209 0 0 0 95. 95.02 DPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113. 113.00 INTEREST EXPENSE 113. 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 16,905,279 2,571,106 237,924 957,066 482,832 118. 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 13,018 21,990 0 8,490 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 256,296 0 0 0 192. 192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 192. 192.02 19203 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192. 194.00 07950 FUNDATI ON<								91.00
OTHER REI MBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVI CES 209 0 113.0 0 113.00 INTEREST EXPECTAL 13.018 21,970 0 8,490 0 190.0 192.00 192.00 IPST, FLOWER, COFFEE SHOP & CANTEEN 13.018 21,990 0 8,490 0 192.01 192.02 PV WABASH HEALTH CLI NC-CASS 0 <			1,010,701	021,072	00,10	121,270	Ū	92.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 16, 905, 279 2, 571, 106 237, 924 957, 066 482, 832 118. NONREI MBURSABLE COST CENTERS 113.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 13, 018 21, 990 0 8, 490 0 192.01 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 256, 296 0 0 0 0 192.01 192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 0 192.02 192.02 19203 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192.02 194.00 07950 FI TNESS CENTER 0 0 0 0 194.02 0 0 0 0 194.02 194.02 07952 NEW DI RECTION 30, 173 14, 255 0 5, 503 0 194.194.02 0 0								
113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 16, 905, 279 2, 571, 106 237, 924 957, 066 482, 832 113. 118.00 NONREI MBURSABLE COST CENTERS 113.00 1900.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 13, 018 21, 990 0 8, 490 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 256, 296 0 0 0 0 192.01 192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 0 192.0 192.02 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192.0 192.03 19203 PV WABASH HEALTH CLINC-KI SSI NGER 0 0 0 0 192.0 194.00 07950 FI TNESS CENTER 0 0 0 0 0 194.0 194.02 07952 NEW DI RECTI ON 30, 173 14, 255 0 5, 503 0 194.1 194.03 07953 COMMUNI TY & VOLUNTEER SER	95.00	09500 AMBULANCE SERVICES	209	0		0 C	0	95.00
I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 16,905,279 2,571,106 237,924 957,066 482,832 118. NONREI MBURSABLE COST CENTERS 13,018 21,990 0 8,490 0 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 256,296 0 0 0 192.01 192.01 PV WABASH HEALTH CLINC-CASS 0 0 0 192.02 19202 PV WABASH HEALTH CLINC-CASS 0 0 0 192.03 192.03 192.03 192.03 192.03 PV WABASH HEALTH CLINC-KI SSI NGER 0 0 0 0 192.02 192.03 192.03 PV WABASH HEALTH CLINC-KI SSI NGER 0 0 0 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.04 0 0 0 0 192.03 194.00 07950 FI TNESS CENTER 0 0 0 0 194.194.25 0 5,503 0 194.194.02 194.02 07952 NEW DI RECTI ON 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
NONRE I MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 13,018 21,990 0 8,490 0 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 256,296 0 0 0 192. 192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 192. 192.02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 192. 192.03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 0 192. 194.00 07950 FI TNESS CENTER 0 0 0 194. 194.01 07951 FOUNDATI ON 30,173 14,255 0 5,503 0 194. 194.02 07952 NEW DI RECTI ON 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11,716 0 0 0 194.								113.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 13,018 21,990 0 8,490 0 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 256,296 0 0 0 192. 192.01 19201 PV WABASH HEALTH CLI NC-CASS 0 0 0 0 192. 192.02 19202 PV WABASH HEALTH CLI NC-N. MANCH 0 0 0 0 192. 192.03 19203 PV WABASH HEALTH CLI NC-N. MANCH 0 0 0 0 192. 192.03 19203 PV WABASH HEALTH CLI NC-KI SSI NGER 0 0 0 0 192. 194.00 07950 FI TNESS CENTER 0 0 0 0 194. 194.01 07951 FOUNDATI ON 30, 173 14, 255 0 5, 503 0 194. 194.02 07952 NEW DI RECTI ON 0 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVI CES 11, 716 0 0 0 0 194. <t< td=""><td>118.00</td><td>SUBTOTALS (SUM OF LINES 1 through 117)</td><td>16, 905, 279</td><td>2, 571, 106</td><td>237, 92</td><td>4 957, 066</td><td>482, 832</td><td>118.00</td></t<>	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 905, 279	2, 571, 106	237, 92	4 957, 066	482, 832	118.00
192.00 PHYSI CI ANS' PRI VATE OFFI CES 256, 296 0 0 0 192.01 192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 192.02 192.02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192.02 192.03 19203 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192.02 192.03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 0 0 192.02 194.00 07950 FI TNESS CENTER 0 0 0 0 194.02 194.01 07951 FOUNDATI ON 30, 173 14, 255 0 5, 503 0 194.02 194.02 07952 NEW DI RECTION 0 0 0 0 194.02 07953 COMMUNI TY & VOLUNTEER SERVICES 11, 716 0 0 0 194.02 07955 0 0 0 0 194.02 07955 0 0 0 0 0 0 194.02 07955 0 0 0 0 </td <td></td> <td></td> <td>10.010</td> <td>01.000</td> <td>1</td> <td></td> <td></td> <td>1.00.00</td>			10.010	01.000	1			1.00.00
192.01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 192. 192.02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 192. 192.03 19203 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 0 192. 192.03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 0 0 192. 194.00 07950 FI TNESS CENTER 0 0 0 0 194. 194.01 07951 FOUNDATI ON 30, 173 14, 255 0 5, 503 0 194. 194.02 07952 NEW DI RECTI ON 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11, 716 0 0 0 194. 194.04 079556 OCUPATI ONAL HEALTH COST CENTERS 0 0 0 0 194. 194.05 07955 OCUPATI ONAL HEALTH 0 0 0 0 0 194.				21, 990				
192.02 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 192.03 192.03 19203 PV WABASH HEALTH CLINC-KI SSINGER 0 0 0 192.03 194.00 07950 FI TNESS CENTER 0 0 0 0 194.01 194.01 07951 FOUNDATI ON 30,173 14,255 0 5,503 0 194.194.02 194.02 07952 NEW DI RECTI ON 0 0 0 0 194.194.02 0 0 0 0 0 194.194.02 0 0 0 0 0 0 194.194.02 0 0 0 0 0 0 0 194.194.02 0 0 0 0 0 0 0 194.02 0 0 0 0 0 194.02 0 0 0 0 0 0 0 0 194.02 0 0 0 0 0 0 0 194.02 0 0 0 0 0 0 0 0 0 0 194.			256, 296	0		0		
192.03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 0 192. 194.00 07950 FITNESS CENTER 0 0 0 0 194. 194.01 07951 FOUNDATION 30,173 14,255 0 5,503 0 194. 194.02 07952 NEW DI RECTION 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11,716 0 0 0 194. 194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 194.05 07955 OCUPATI ONAL HEALTH 0 0 0 0 194.			0					
194.00 07950 FI TNESS CENTER 0 0 0 194. 194.01 07951 FOUNDATI ON 30, 173 14, 255 0 5, 503 0 194. 194.02 07952 NEW DI RECTI ON 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11, 716 0 0 0 194. 194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 194.04 07956 OCUPATI ONAL HEALTH 0 0 0 0 194.								192.02
194.01 07951 FOUNDATION 30,173 14,255 0 5,503 0 194. 194.02 07952 NEW DI RECTION 0 0 0 0 194. 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11,716 0 0 0 194. 194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 194.05 07955 OCUPATI ONAL HEALTH 0 0 0 0 194.								192.03
194.02 07952 NEW DI RECTION 0 0 0 0 194.03 194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11,716 0 0 0 194. 194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 194.05 07955 OCCUPATI ONAL HEALTH 0 0 0 0 194.			30 173	14 255		5 503		194.00
194.03 07953 COMMUNI TY & VOLUNTEER SERVICES 11,716 0 0 0 194.04 194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.04 194.05 07955 OCCUPATI ONAL HEALTH 0 0 0 0 0 194.05			0,175	0		0,000		194.02
194.04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194.05 194.05 07955 OCCUPATI ONAL HEALTH 0 0 0 0 0 194.			11, 716	l o		o o		194.03
194. 05 07955 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 194.			0	0		0 0		194.04
200 00 Cross Foot Adjustments 200		07955 OCCUPATI ONAL HEALTH	0	0		0 0		194.05
	200.00							200.00
			0	0		0 0		201.00
202.00 TOTAL (sum Lines 118 through 201) 17,216,482 2,607,351 237,924 971,059 482,832 202.	202.00	ן ווואב (sum lines 118 through 201)	17, 216, 482	2, 607, 351	237, 92	4 971, 059	482, 832	202.00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/26/2023 3:0	epared:)9 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS		1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL						5.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	1, 579, 303					11.00
13.00	01300 NURSING ADMINISTRATION	58, 041					13.00
15.00	01500 PHARMACY	99, 574		2,043,3	83		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	345, 629	516, 683		0 0	6, 595, 921	30.00
43.00	04300 NURSERY	13, 626	20, 445		0 0	243, 679	43.00
	ANCI LLARY SERVICE COST CENTERS	450.057	007.001				
50.00	05000 OPERATING ROOM	159, 057			0 0	4, 193, 468	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 50, 835			0 0 0 0	052 574	
52.00	05300 ANESTHESI OLOGY	50, 835	75, 924 0		0 0	952, 574 0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	244, 350				4, 637, 071	
60.00	06000 LABORATORY	244, 330			0 0	3, 766, 728	
66.00	06600 PHYSI CAL THERAPY	176, 614			0 0	1, 948, 288	
67.00	06700 OCCUPATI ONAL THERAPY	22, 142			0 0	393, 830	
68.00	06800 SPEECH PATHOLOGY	11, 792			0 0	174, 356	
69.00	06900 ELECTROCARDI OLOGY	101, 409	0		0 0	1, 948, 654	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	157, 513	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	1, 337, 059	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	2,043,3	83 0	7, 800, 076	73.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0			0 0	0	
88.01 88.02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0			0 0	4, 238, 855 11, 055, 910	
90.00	09000 CLINIC	18, 474	-		0 0	179, 341	
90.00	09001 SENI OR CARE	97, 609			0 0	1, 471, 926	
91.00	09100 EMERGENCY	180, 151			0 0	5, 392, 371	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	100,101	20,707,7		0	0,0,2,0,1	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0		0 0	700	95.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00		1, 579, 303	1, 120, 252	2,043,3	83 0	56, 488, 320	118.00
100.00	NONREI MBURSABLE COST CENTERS					74.040	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS	0	0		0 0	857, 165	
	19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0		0 0		192.01 192.02
	19203 PV WABASH HEALTH CLINC-N. MANGH		0		0 0		192.02
	07950 FI TNESS CENTER		0		0 0		192.03
	07951 FOUNDATI ON	0	0		0 0	120, 670	
	07952 NEW DI RECTI ON	0	0		0 0		194.02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	Ő		0 0		194.03
	07956 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.04
	07955 OCCUPATI ONAL HEALTH	0	0		0 0		194.05
200.00						0	200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
201.00 202.00	Ű,	1, 579, 303	1, 120, 252	2,043,3	83 0	57, 579, 358	

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1310	Peri od:	Worksheet B	
				From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
Cost Center Description	Intern &	Total			5/20/2025 5.0	
	Resi dents	. o cui				
	Cost & Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	6, 595, 921				30.00
43.00 04300 NURSERY	0	243, 679				43.00
ANCI LLARY SERVI CE COST CENTERS	-					
50. 00 05000 OPERATING ROOM	0	4, 193, 468				50.00
51.00 O5100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	952, 574				52.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 637, 071				54.00
60. 00 06000 LABORATORY	0	3, 766, 728				60.00
66.00 06600 PHYSI CAL THERAPY	0	1, 948, 288				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	393, 830				67.00
68. 00 06800 SPEECH PATHOLOGY	0	174, 356				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 948, 654				69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	157, 513				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 337, 059				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	7, 800, 076				/3.00
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
88.01 08801 RURAL HEALTH CLINIC II	0	4, 238, 855				88.01
88. 02 08802 RURAL HEALTH CLINIC III	0	11, 055, 910				88.02
90. 00 09000 CLINIC	0	179, 341				90.00
90. 01 09001 SENI OR CARE	0	1, 471, 926				90.01
91. 00 09100 EMERGENCY	0	5, 392, 371				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-,,				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	700				95.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 0	56, 488, 320				118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74, 019				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	857, 165				192.00
192.01 19201 PV WABASH HEALTH CLINC-CASS	0	0				192.01
192.02 19202 PV WABASH HEALTH CLINC-N.MANCH	0	0				192.02
192.03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0				192.03
194.0007950 FI TNESS CENTER	0	0				194.00
194. 01 07951 FOUNDATI ON	0	120, 670				194.01
194. 02 07952 NEW DI RECTI ON	0	0				194.02
194.0307953 COMMUNITY & VOLUNTEER SERVICES	0	39, 184				194.03
194.04 07956 OTHER NONREI MBURSABLE COST CENTERS	0	0				194.04
194.0507955 OCCUPATI ONAL HEALTH	0	0				194.05
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	57, 579, 358				202.00

	ARKVIEW WABASH				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part II Date/Time Pre 5/26/2023 3:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	о	0	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	2, 513, 726	885, 412	400, 983	3, 800, 121	0	5.00
7.00 00700 OPERATION OF PLANT	0	367, 070	166, 238	533, 308	0	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	0	0	0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	69, 168 79, 327	31, 325 35, 926	100, 493 115, 253	0	9.00
11. 00 01100 CAFETERIA	0	141, 611	64, 133	205, 744	0	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	0	6, 096	2, 761	8, 857	0	13.00
15.00 01500 PHARMACY	0	117, 021	52, 996	170, 017	0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	295, 041	133, 618	428, 659	0	30.00
43. 00 04300 NURSERY	0	4, 271	1, 934	6, 205	0	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	312, 748	141, 637	454, 385	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	0	27, 991	12, 676	40, 667	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	263, 526	119, 345	382, 871	0	54.00
60. 00 06000 LABORATORY	0	144, 473	65, 429	209, 902	0	60.00
66.00 06600 PHYSI CAL THERAPY	0	11, 777	5, 333	17, 110	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	2, 488	1, 127	3, 615	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 078	488	1, 566	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	118, 473 0	53, 654 0	172, 127 0	0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	17, 505	0		17, 505	0	
88.01 08801 RURAL HEALTH CLINIC II	67, 245	0	0	67, 245	0	88.01
88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC	397, 050	0 4, 727	0 2, 141	397, 050 6, 868	0	88.02 90.00
90. 01 09001 SENI OR CARE	0	88, 284	39, 982	128, 266	0	90.00
91. 00 09100 EMERGENCY	0	241, 589	109, 411	351,000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 995, 526	3, 182, 171	1, 441, 137	7, 618, 834	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16, 504	7, 474			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	427, 132	0	0	427, 132		192.00
192.01 19201 PV WABASH HEALTH CLINC-CASS 192.02 19202 PV WABASH HEALTH CLINC-N.MANCH	0	0		0		192.01 192.02
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192.02
194.0007950 FITNESS CENTER	0	0	0	0		194.00
194. 01 07951 FOUNDATI ON	0	10, 699	4, 845	15, 544		194.01
194. 02 07952 NEW DI RECTI ON	0	0	0	0		194.02
194. 03 07953 COMMUNITY & VOLUNTEER SERVICES	0	0	0	0		194.03
194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS 194. 05 07955 OCCUPATI ONAL HEALTH	0	0	0	0		194.04 194.05
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 422, 658	3, 209, 374	1, 453, 456	8, 085, 488	0	202.00

Cost Center Des	ED COSTS		Provider C		Period:	Worksheet B	
					rom 01/01/2022 o 12/31/2022	Part II Date/Time Pre 5/26/2023 3:0	
	cription	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST		1		1	1		
1.00 00100 CAP REL COSTS-B							1.00
2.00 00200 CAP REL COSTS-M 4.00 00400 EMPLOYEE BENEFI							2.00
4.00 00400 EMPLOYEE BENEFI 5.00 00500 ADMI NI STRATI VE 8		3, 800, 121					4.00 5.00
7.00 00700 OPERATION OF PL		3, 800, 121	705, 388				7.00
8.00 00800 LAUNDRY & LI NEN		15, 703	705, 388		2		8.00
9. 00 00900 HOUSEKEEPI NG	SERVICE	58,006	24, 932				9.00
10. 00 01000 DI ETARY		22, 197	28, 595			173, 753	
11. 00 01100 CAFETERI A		86, 971	51, 046			0	11.00
13.00 01300 NURSING ADMINIS	TRATION	69, 361	2, 197			0	
15.00 01500 PHARMACY		113, 996	42, 182	28	3 11, 371	0	15.00
16.00 01600 MEDICAL RECORDS	& LI BRARY	0	0	c		0	16.00
INPATIENT ROUTINE SER	VICE COST CENTERS						
30. 00 03000 ADULTS & PEDI AT	RICS	306, 243	106, 352			173, 753	30.00
43.00 04300 NURSERY		13, 215	1, 540	98	3 415	0	43.00
ANCILLARY SERVICE COS	T CENTERS						
50.00 05000 OPERATING ROOM		210, 513	112, 734			0	50.00
51.00 05100 RECOVERY ROOM		0	0		-	0	51.00
52.00 05200 DELIVERY ROOM &	LABOR ROOM	50, 727	10, 090			0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGN		0	0		-	0	53.00
54. 00 05400 RADI OLOGY-DI AGN 60. 00 06000 LABORATORY	JSTIC	254, 539 230, 988	94, 991 52, 077	3, 252		0	54.00 60.00
66. 00 06600 PHYSI CAL THERAP	V	115, 492	4, 245			0	66.00
67. 00 06700 OCCUPATI ONAL TH		24, 227	897			0	67.00
68.00 06800 SPEECH PATHOLOG		10, 597	389			0	68.00
69.00 06900 ELECTROCARDI OLO		107, 475	42, 705			0	69.00
71.00 07100 MEDICAL SUPPLIES		10, 396	0			0	71.00
72.00 07200 I MPL. DEV. CHAR		88, 243	0			0	72.00
73.00 07300 DRUGS CHARGED TO	D PATI ENTS	379, 931	0		0 0	0	73.00
OUTPATIENT SERVICE CO	ST CENTERS						
88.00 08800 RURAL HEALTH CL	INIC	0	0	C	0 0	0	88.00
88.01 08801 RURAL HEALTH CL		279, 756	0	C	0 0	0	88.01
88.02 08802 RURAL HEALTH CL	INIC III	729, 661	0		0 0	0	88.02
90. 00 09000 CLI NI C		10, 041	1, 704			0	90.00
90. 01 09001 SENI OR CARE		79, 942	31, 823		-,	0	90.01
91.00 09100 EMERGENCY		291, 084	87, 084	5, 688	3 23, 475	0	91.00
92.00 09200 OBSERVATI ON BED							92.00
95.00 09500 AMBULANCE SERVI		46	0	C	0	0	95.00
SPECIAL PURPOSE COST		40	0			0	95.00
113. 00 11300 I NTEREST EXPENSI							113.00
	DF LINES 1 through 117)	3, 731, 430	695, 583	15, 703	180, 787	173, 753	•
NONREI MBURSABLE COST		0,701,100	0,0,000	10,700	1007707	1101100	
190.00 19000 GIFT, FLOWER, CO		2, 874	5, 949	0	1, 604	0	190.00
192.00 19200 PHYSI CLANS' PRI		56, 571	0			0	192.00
192.01 19201 PV WABASH HEALTI		0	0	0	0 0	0	192.01
192.02 19202 PV WABASH HEALT	H CLINC-N. MANCH	0	0	C	0 0	0	192.02
192.03 19203 PV WABASH HEALTI	H CLINC-KISSINGER	0	0	0	0 0		192.03
194.0007950 FITNESS CENTER		0	0	C	0 0		194.00
194.0107951 FOUNDATI ON		6, 660	3, 856	C	1, 040		194.01
194.0207952 NEW DIRECTION		0	0	C	0 0		194.02
194. 03 07953 COMMUNI TY & VOLI		2, 586	0	C	0		194.03
194. 04 07956 OTHER NONREI MBU		0	0		0		194.04
194. 05 07955 OCCUPATI ONAL HEA		0	0		0	0	194.05
200.00Cross Foot Adjust201.00Negative Cost Cost			_	-		0	200.00 201.00
	s 118 through 201)	3, 800, 121	705, 388	15, 703	183, 431	0 173, 753	
	3 110 through 201)	3,000,121	105, 300	1 15,703	103,431	173,703	1202.00

ALLOC/	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/26/2023 3:0	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
	GENERAL SERVICE COST CENTERS				TT		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
3.00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	357, 521					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	13, 139		0/0.4/			13.00
15.00	01500 PHARMACY	22, 542		360, 13			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0		16.00
30.00	03000 ADULTS & PEDIATRICS	78, 242	43, 422		0 0	1, 169, 677	30.00
43.00	04300 NURSERY	3, 085			0 0	26, 276	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	36, 007	19, 986		0 0	865, 952	50.00
51.00	05100 RECOVERY ROOM	0	-		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 508			0 0	122, 457	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 316	0		0 0	816, 576	
50.00 56.00	06000 LABORATORY 06600 PHYSI CAL THERAPY	0 39, 982	0		0 0	507, 005 177, 973	
67.00	06700 OCCUPATI ONAL THERAPY	5, 013			0 0	33, 994	
68.00	06800 SPEECH PATHOLOGY	2,669			0 0	15, 326	
69.00	06900 ELECTROCARDI OLOGY	22, 957	0		0 0	356, 776	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	10, 396	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	88, 243	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	360, 13	36 0	740, 067	73.00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0			17 505	88.00
38.00 38.01	08800 RURAL HEALTH CLINIC	0			0 0	17, 505 347, 001	
38. 02	08802 RURAL HEALTH CLINIC III	0			0 0	1, 126, 711	
90.00	09000 CLINIC	4, 182			0 0	23, 254	
90.01	09001 SENI OR CARE	22, 097	0		0 0	270, 707	
91.00	09100 EMERGENCY	40, 782	22, 639		0 0	821, 752	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
25 00	OTHER REIMBURSABLE COST CENTERS						1 05 00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0		0 0	46	95.00
113 00	11300 INTEREST EXPENSE						113.00
118.00		357, 521	94, 146	360, 13	36 0	7, 537, 694	
	NONREI MBURSABLE COST CENTERS	0017021	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	000, 10		110011071	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	34, 405	190.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0	483, 703	192.00
	19201 PV WABASH HEALTH CLINC-CASS	0	0		0 0		192.01
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0		0 0		192.02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	0		0 0		192.03
	07950 FI TNESS CENTER 07951 FOUNDATI ON	0	0		0 0		194.00 194.01
	07951 FOUNDATION 07952 NEW DIRECTION	0			0 0		194.01
	07953 COMMUNITY & VOLUNTEER SERVICES	0			0 0		194.02
	07956 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.03
	07955 OCCUPATI ONAL HEALTH	0	Ő		0 0		194.05
200.00		-					200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	357, 521	94, 146	360, 13	36 0	8, 085, 488	

Heal th	Financial Systems PA	ARKVIEW WABASH I	HOSPITAL, INC.		In Lieu	ı of Form CMS-	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1310	Period: From 01/01/2022	Worksheet B Part II Date/Time Pro 5/26/2023 3:0	epared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			0, 20, 2020 0.	
		25.00	26.00				
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 00
1.00 2.00	00200 CAP REL COSTS-BEDG & FIXT						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00							11.00
13.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY						13.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	II	I				10.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 169, 677				30.00
43.00	04300 NURSERY	0	26, 276				43.00
	ANCILLARY SERVICE COST CENTERS	,,					
50.00	05000 OPERATING ROOM	0	865, 952				50.00
51.00	05100 RECOVERY ROOM	0	100 157				51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	122, 457 0				52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	816, 576				54.00
60.00	06000 LABORATORY	0	507,005				60.00
66.00	06600 PHYSI CAL THERAPY	0	177, 973				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	33, 994				67.00
68.00	06800 SPEECH PATHOLOGY	0	15, 326				68.00
69.00	06900 ELECTROCARDI OLOGY	0	356, 776				69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	10, 396 88, 243				71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	740, 067				73.00
101.00	OUTPATIENT SERVICE COST CENTERS		, 10, 00, 1				
88.00	08800 RURAL HEALTH CLINIC	0	17, 505				88.00
88.01	08801 RURAL HEALTH CLINIC II	0	347, 001				88.01
88.02	08802 RURAL HEALTH CLINIC III	0	1, 126, 711				88.02
90.00	09000 CLINIC 09001 SENIOR CARE	0	23, 254				90.00
90.01 91.00	09100 EMERGENCY	0	270, 707 821, 752				90.01 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	021,752				92.00
	OTHER REIMBURSABLE COST CENTERS	-1	I				
95.00	09500 AMBULANCE SERVI CES	0	46				95.00
	SPECIAL PURPOSE COST CENTERS	<u>г</u>					
	11300 INTEREST EXPENSE		7 507 (04				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	7, 537, 694				118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34, 405				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	483, 703				192.00
	19201 PV WABASH HEALTH CLINC-CASS	0	0				192.01
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0				192.02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	0				192.03
	07950 FI TNESS CENTER	0	0				194.00
	07951 FOUNDATION 07952 NEW DIRECTION	0	27, 100				194.01 194.02
	07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES	0	2, 586				194.02 194.03
	07956 OTHER NONREI MBURSABLE COST CENTERS	0	2, 330				194.03
	07955 OCCUPATI ONAL HEALTH	Ő	0				194.05
200.00	· · · · · · · · · · · · · · · · · · ·	0	0				200.00
201.00		0	0				201.00
202.00	TOTAL (sum lines 118 through 201)	0	8, 085, 488				202.00

	- STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2022	Worksheet B-1	
				Т	0 12/31/2022	Date/Time Pre 5/26/2023 3:0	
		CAPI TAL REI	LATED COSTS				
Cos	t Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	SERVICE COST CENTERS	77 205			1	1	1 1
	REL COSTS-BLDG & FIXT	77, 395	77, 395				
	LOYEE BENEFITS DEPARTMENT	0	0	20, 042, 750			4
00 00500 ADN	II NI STRATI VE & GENERAL	21, 352	21, 352	4, 981, 187		40, 362, 876	5
	RATION OF PLANT	8, 852		303, 244		1, 827, 742	
	NDRY & LINEN SERVICE	0	0	0	0	166, 784	
00 00900 HOL . 00 01000 DI E	ISEKEEPI NG	1, 668 1, 913		323, 985 64, 800	0	616, 105 235, 766	
. 00 01100 DTL		3, 415		524, 508	-	923, 755	
	SING ADMINISTRATION	147		542, 892	0	736, 714	
. 00 01500 PHA		2, 822	2, 822	714, 003	0	1, 210, 809	
	I CAL RECORDS & LI BRARY	0	0	0	0	0	16
	ROUTINE SERVICE COST CENTERS	7, 115	7, 115	1, 901, 441	0	3, 252, 749	30
. 00 04300 NUR		103		89, 114	0	140, 361	
ANCI LLARY	SERVICE COST CENTERS						
. 00 05000 OPE		7, 542		947, 162		2, 235, 954	
. 00 05100 REC		0	-	0	0	0	
. 00 05200 DEL . 00 05300 ANE	IVERY ROOM & LABOR ROOM	675		330, 884	0	538, 794 0	
	I OLOGY-DI AGNOSTI C	6, 355	-	1, 205, 296	-	2, 703, 576	
. 00 06000 LAE		3, 484		0	0	2, 453, 426	
. 00 06600 PHY	SI CAL THERAPY	284	284	884, 043	0	1, 226, 690	66
	UPATIONAL THERAPY	60		185, 433	0	257, 331	
	ECH PATHOLOGY	26		81, 122		112, 560	
	CTROCARDIOLOGY	2,857		649, 018 0	0	1, 141, 537 110, 416	
	L. DEV. CHARGED TO PATIENTS	0	-	0	0	937, 273	
. 00 07300 DRL	GS CHARGED TO PATIENTS	0	0	0	0	4, 035, 418	
	IT SERVICE COST CENTERS						
	AL HEALTH CLINIC AL HEALTH CLINIC II	0	-	0 1, 354, 089		0 2, 971, 420	
	AL HEALTH CLINIC III	0	-	3, 352, 278	0	7, 750, 130	
. 00 09000 CLI	NIC	114		70, 465	0	106, 647	
. 01 09001 SEN		2, 129				849, 098	
. 00 09100 EME		5, 826	5, 826	975, 667	0	3, 091, 733	
	ERVATION BEDS (NON-DISTINCT PART MBURSABLE COST CENTERS						92
	ULANCE SERVICES	0	0	1, 494	0	491	95
SPECIAL F	PURPOSE COST CENTERS						
	EREST EXPENSE						113
	TOTALS (SUM OF LINES 1 through 117) JRSABLE COST CENTERS	76, 739	76, 739	19, 962, 793	-17, 216, 482	39, 633, 279	1118
	T, FLOWER, COFFEE SHOP & CANTEEN	398	398	0	0	30, 521	1190
	SICIANS' PRIVATE OFFICES	0			0	600, 869	
	WABASH HEALTH CLINC-CASS	0	0	0	0		192
	WABASH HEALTH CLINC-N. MANCH	0	-	0	0		192
	WABASH HEALTH CLINC-KISSINGER	0	-	0	0		192
4. 00 07950 FI T 4. 01 07951 FOL		0 258	-		0	70, 739	194
4. 02 07952 NEW		230	230	0	0		194
	MUNITY & VOLUNTEER SERVICES	0	0	0	-	27, 468	
	ER NONREIMBURSABLE COST CENTERS	0	0	0	0		194
	UPATIONAL HEALTH	0	0	0	0	0	194
	ess Foot Adjustments ative Cost Centers						200
	it to be allocated (per Wkst. B,	3, 209, 374	1, 453, 456	6, 571, 210		17, 216, 482	
Par	tl)						
	t cost multiplier (Wkst. B, Part I)	41. 467459	18. 779714	0. 327860		0. 426542	
	t to be allocated (per Wkst. B, t II)			0		3, 800, 121	204
	t cost multiplier (Wkst. B, Part			0. 000000		0. 094149	205
1)							
	E adjustment amount to be allocated er Wkst. B-2)						206
	E unit cost multiplier (Wkst. D,						207
	ts III and IV)	1			1	1	1

	ARKVI EW WABASH		ON 15 1310 D		u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre	
					5/26/2023 3:0	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
	7.00	LAUNDR) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS			1			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION	47, 191 C 1, 668 1, 913 3, 415 147	23, 017 0 0 0 0 0	45, 523 1, 913 3, 415 147	15, 775 0 0	12, 054 443	13.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL_RECORDS_&_LI BRARY	2,822		2, 822 0	0	760 0	•
INPATIENT ROUTINE SERVICE COST CENTERS			· · · · · ·			
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	7, 115			15, 775 0	2, 638 104	30.00 43.00
ANCILLARY SERVICE COST CENTERS		1		-		1
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	7, 542 C 675 C	0 533	0 675	0 0 0	1, 214 0 388 0	51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 66. 00 06600 PHYSI CAL THERAPY	6, 355 3, 484 284	4, 767 0	-	0	1, 865 0 1, 348	54.00 60.00
67. 00 06700 OCCUPATI ONAL THERAPY	60		60	0	1, 348	
68.00 06800 SPEECH PATHOLOGY	26		26	0	90	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2, 857 C		2, 857 0	0	774 0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	C	0	0	0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III			0	0	0	88.01 88.02
90. 00 09000 CLINIC	114		114	0	141	
90. 01 09001 SENI OR CARE 91. 00 09100 EMERGENCY	2, 129		2, 129	0	745	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 826	8,338	5, 826	0	1, 375	91.00 92.00
OTHER REI MBURSABLE COST CENTERS			_	-		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	C	C	0	0	0	95.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	46, 535	23, 017	44, 867	15, 775	12, 054	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	398	0	398	0	0	190.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 192.01 19201 PV WABASH HEALTH CLINC-CASS			0	0		192.00
192. 02 19201 PV WABASH HEALTH CLINC-CASS 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH		-	0	0		192.01 192.02
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	C	0	0	0		192.03
194. 00 07950 FI TNESS_CENTER 194. 01 07951 FOUNDATI ON	258		0 258	0		194.00 194.01
194. 02 07952 NEW DI RECTI ON	0	0	0	0		194.02
194. 03 07953 COMMUNI TY & VOLUNTEER SERVICES	C	0	0	0		194.03
194.04 07956 0THER NONREIMBURSABLE COST CENTERS 194.05 07955 0CCUPATIONAL HEALTH			0	0		194.04 194.05
200.00 Cross Foot Adjustments			Ŭ	0	0	200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	2, 607, 351	237, 924	971, 059	482, 832	1, 579, 303	201.00
203.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	55. 251022	10. 336881	21. 331173	30. 607417	131. 018998	203.00
204.00Cost to be allocated (per Wkst. B, Part II)205.00Unit cost multiplier (Wkst. B, Part	705, 388			173, 753 11. 014453	357, 521 29. 659947	
206.00 NAHE adjustment amount to be allocated	1					206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

ST ALLOC	ancial Systems P/ CATION - STATISTICAL BASIS	ARKVIEW WABASH H	Provi der CC		Period:	u of Form CMS-2552 Worksheet B-1
					From 01/01/2022 To 12/31/2022	Date/Time Prepare
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		5/26/2023 3:09 pr
	cost center bescription	ADMI NI STRATI O	(COSTED	RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DI RECT_NRS		(GROSS REV)		
		I NG HR) 13.00	15.00	16.00	_	
GENE	ERAL SERVICE COST CENTERS	13.00	13.00	10.00		
00 0010	DO CAP REL COSTS-BLDG & FIXT					1
	DO CAP REL COSTS-MVBLE EQUIP					2
	DO EMPLOYEE BENEFITS DEPARTMENT					4
	DO ADMI NI STRATI VE & GENERAL					5
	DO OPERATION OF PLANT DO LAUNDRY & LINEN SERVICE					7
	DO HOUSEKEEPI NG					9
	DO DI ETARY					10
00 0110	DO CAFETERI A					11
	DO NURSING ADMINISTRATION	118, 954				13
		0	25, 519			15
	DO MEDICAL RECORDS & LIBRARY ATIENT ROUTINE SERVICE COST CENTERS	0	0		0	16
	DO ADULTS & PEDIATRICS	54, 864	0		0	30
	DO NURSERY	2, 171	0		0	43
	LLARY SERVICE COST CENTERS	_,			-1	
	DO OPERATING ROOM	25, 253	0		0	50
	DO RECOVERY ROOM	0	0		0	51
1	DO DELIVERY ROOM & LABOR ROOM	8, 062	0		0	52
		0	0		0	53
	00 RADI OLOGY-DI AGNOSTI C 00 LABORATORY	0	0		0	54
	DO PHYSI CAL THERAPY	0	0		0	66
	DO OCCUPATI ONAL THERAPY	0	0		0	67
00 0680	DO SPEECH PATHOLOGY	0	0		0	68
	DO ELECTROCARDI OLOGY	0	0		0	69
	DO MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	71
	DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS	0	0 25, 519		0	72
	PATIENT SERVICE COST CENTERS	0	25, 519			73
	DO RURAL HEALTH CLINIC	0	0		0	88
01 0880	D1 RURAL HEALTH CLINIC II	0	0		0	88
	D2 RURAL HEALTH CLINIC III	0	0		0	88
		0	0		0	90
	D1 SENI OR CARE D0 EMERGENCY	0 28, 604	0		0	90
	DO OBSERVATION BEDS (NON-DISTINCT PART	20, 004	0		0	91
	ER REIMBURSABLE COST CENTERS	1 1				
00 0950	DO AMBULANCE SERVICES	0	0		0	95
	CLAL PURPOSE COST CENTERS					
	DO INTEREST EXPENSE	110.051	05 540			113
3. 00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	118, 954	25, 519		0	118
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190
	DO PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192
2. 01 1920	D1 PV WABASH HEALTH CLINC-CASS	0	0		0	192
	D2 PV WABASH HEALTH CLINC-N. MANCH	0	0		0	192
	D3 PV WABASH HEALTH CLINC-KISSINGER	0	0		0	192
	50 FI TNESS CENTER 51 FOUNDATI ON	0	0		0	194 194
	52 NEW DIRECTION	0	0		0	194
	53 COMMUNITY & VOLUNTEER SERVICES	0	0		0	194
	56 OTHER NONREI MBURSABLE COST CENTERS	o o	0		0	194
	55 OCCUPATIONAL HEALTH	0	0		0	194
0.00	Cross Foot Adjustments					200
1.00	Negative Cost Centers	1 100 050	2 040 000			201
2.00	Cost to be allocated (per Wkst. B, Part I)	1, 120, 252	2, 043, 383		0	202
3. 00	Unit cost multiplier (Wkst. B, Part I)	9. 417523	80. 073004	0. 00000	0	203
1.00	Cost to be allocated (per Wkst. B,	94, 146	360, 136	5. 00000	ō	203
	Part II)					
5.00	Unit cost multiplier (Wkst. B, Part	0. 791449	14. 112465	0.00000	0	205
4 00	II)					001
6. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206
7.00	NAHE unit cost multiplier (Wkst. D,					207
		1			1	

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	PARKVI EW WABASH	Provider C	CN. 15 1210	Period:	u of Form CMS-2 Worksheet C	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre	pared:
					5/26/2023 3:0	19 pm
			XVIII	Hospi tal	Cost	1
	Table Oral	T I	Talah Quala	Costs	Tabab Osala	
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I,	Auj.		DI Sal i Owance		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	6, 595, 921		6, 595, 92	21 0	0	30.0
43. 00 04300 NURSERY	243, 679		243, 67			
ANCI LLARY SERVICE COST CENTERS	210,077		210,07	<u>, </u>		10.0
50. 00 05000 OPERATI NG ROOM	4, 193, 468		4, 193, 46	0 8	0	50.0
51.00 05100 RECOVERY ROOM	0			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	952, 574		952, 57	4 0	0	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	4,637,071		4, 637, 07	1 0	0	54.0
60. 00 06000 LABORATORY	3, 766, 728		3, 766, 72		0	60.0
66.00 06600 PHYSI CAL THERAPY	1, 948, 288	0	1, 948, 28	0 8	0	66.0
67.00 06700 OCCUPATI ONAL THERAPY	393, 830	0	393, 83	0 0	0	67.0
68.00 06800 SPEECH PATHOLOGY	174, 356	0	174, 35	6 0	0	68.0
69. 00 06900 ELECTROCARDI OLOGY	1, 948, 654		1, 948, 65	64 0	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157, 513		157, 51	3 0	0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 337, 059		1, 337, 05	i9 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 800, 076		7, 800, 07	6 0	0	73.0
OUTPATIENT SERVICE COST CENTERS			-			
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
88.01 08801 RURAL HEALTH CLINIC II	4, 238, 855		4, 238, 85		0	
88.02 08802 RURAL HEALTH CLINIC III	11, 055, 910		11, 055, 91	0 0	0	
90. 00 09000 CLINIC	179, 341		179, 34		0	90.0
90. 01 09001 SENI OR CARE	1, 471, 926		1, 471, 92		0	
91. 00 09100 EMERGENCY	5, 392, 371		5, 392, 37		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 134, 471		2, 134, 47	'1	0	92.0
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVICES	700		70	0 0	0	95.0
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.0
200.00 Subtotal (see instructions)	58, 622, 791	0				200. 0
201.00 Less Observation Beds	2, 134, 471		2, 134, 47			201.0
202.00 Total (see instructions)	56, 488, 320	0	56, 488, 32	0 0	0	202.0

Health Financial Systems P	ARKVIEW WABASH I	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1310	Peri od:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	nored.
				10 12/31/2022	5/26/2023 3:0	9 pm
		Title	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 248, 437		6, 248, 43			30.00
43. 00 04300 NURSERY	236, 211		236, 2	1		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	2, 517, 730	13, 434, 883	15, 952, 6		0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	801, 801	82, 417	884, 21		0.000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 641, 703	33, 131, 884			0.00000	
60. 00 06000 LABORATORY	2, 852, 510	25, 012, 183			0.000000	
66. 00 06600 PHYSI CAL THERAPY	365, 443	4, 920, 959			0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	269, 415	499, 377			0.000000	
68.00 06800 SPEECH PATHOLOGY	94, 290	303, 135			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	2, 268, 743				0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	304, 220				0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	342, 277				0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 630, 787	34, 370, 775	38, 001, 50	0. 205257	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · ·		1			
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 144, 872				88.01
88.02 08802 RURAL HEALTH CLINIC III	0	9, 982, 731				88.02
90. 00 09000 CLINIC	6, 884	961, 263			0. 000000	
90. 01 09001 SENI OR CARE	239	2, 175, 627			0. 000000	
91. 00 09100 EMERGENCY	1, 217, 713	35, 375, 478			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 527	2, 553, 831	2, 578, 3	0. 827841	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1 1					
95. 00 09500 AMBULANCE SERVICES	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)	22, 822, 930	179, 696, 344	202, 519, 2	4		200.00
201.00 Less Observation Beds		470 /0/ 51				201.00
202.00 Total (see instructions)	22, 822, 930	179, 696, 344	202, 519, 2	4		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pro 5/26/2023 3:0	eparec 09 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					4
0.00 03000 ADULTS & PEDIATRICS					30.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM	0. 000000				50.
1.00 05100 RECOVERY ROOM	0. 000000				51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
3. 00 05300 ANESTHESI OLOGY	0. 000000				53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
0. 00 06000 LABORATORY	0. 000000				60.
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.
8.00 06800 SPEECH PATHOLOGY	0. 000000				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	INT 0. 000000				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC					88.
8.01 08801 RURAL HEALTH CLINIC II					88.
8.02 08802 RURAL HEALTH CLINIC III					88.
0. 00 09000 CLINIC	0. 000000				90.
0. 01 09001 SENI OR CARE	0. 000000				90.
1.00 09100 EMERGENCY	0. 000000				91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART 0. 000000				92.
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES	0. 000000				95.
SPECIAL PURPOSE COST CENTERS	· · · · ·				
13.00 11300 INTEREST EXPENSE					113.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					201.
02.00 Total (see instructions)					202.

leal th COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1310	Period:	Worksheet C	2552-1
					From 01/01/2022	Part I	
					To 12/31/2022	Date/Time Pre 5/26/2023 3:0	epared:
				e XIX	Hospi tal	PPS	,, b
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	6 505 004		6 505 00		1 505 004	
	03000 ADULTS & PEDIATRICS	6, 595, 921		6, 595, 92		6, 595, 921	
	04300 NURSERY	243, 679		243, 67	9 0	243, 679	43.00
	NCILLARY SERVICE COST CENTERS	4 400 440		4 400 4/		4 400 4/0	1 50 0
	D5000 OPERATING ROOM	4, 193, 468		4, 193, 46		4, 193, 468	
	D5100 RECOVERY ROOM	0			0 0	0	
	D5200 DELIVERY ROOM & LABOR ROOM	952, 574		952, 57		952, 574	
	05300 ANESTHESI OLOGY	0			0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	4, 637, 071		4, 637, 07		4, 637, 071	
	06000 LABORATORY	3, 766, 728		3, 766, 72		3, 766, 728	
	06600 PHYSI CAL THERAPY	1, 948, 288				1, 948, 288	
	06700 OCCUPATI ONAL THERAPY	393, 830		0,0,00		393, 830	
	06800 SPEECH PATHOLOGY	174, 356		174, 35		174, 356	
	06900 ELECTROCARDI OLOGY	1, 948, 654		1, 948, 65		1, 948, 654	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	157, 513		157, 51		157, 513	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 337, 059		1, 337, 05		1, 337, 059	
	07300 DRUGS CHARGED TO PATIENTS	7, 800, 076		7, 800, 07	0 0	7, 800, 076	73.0
	08800 RURAL HEALTH CLINIC	0			0 0	0	88.0
	08800 RURAL HEALTH CLINIC	4, 238, 855		4, 238, 85		4, 238, 855	
	08802 RURAL HEALTH CLINIC III	4, 238, 855		4, 238, 83		4, 238, 855	
	09000 CLINIC	179, 341		179, 34		179, 341	
	09001 SENI OR CARE	1, 471, 926		1, 471, 92		1, 471, 926	
	09100 EMERGENCY	5, 392, 371		5, 392, 37		5, 392, 371	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 134, 471		2, 134, 47		2, 134, 471	
	THER REIMBURSABLE COST CENTERS	2,134,471		2,134,47	1	2, 134, 471	92.0
	09500 AMBULANCE SERVICES	700		70	0 0	700	95.0
	SPECIAL PURPOSE COST CENTERS	/00	1	1 70	0	/00	75.0
	11300 INTEREST EXPENSE			1			113.0
200.00	Subtotal (see instructions)	58, 622, 791	c	58, 622, 79	0	58, 622, 791	
200.00	Less Observation Beds	2, 134, 471		2, 134, 47		2, 134, 471	
201.00	Total (see instructions)	56, 488, 320				56, 488, 320	

	ARKVIEW WABASH I				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1310	Period:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	narod
				10 12/31/2022	5/26/2023 3:0	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	- F		-			
30. 00 03000 ADULTS & PEDIATRICS	6, 248, 437		6, 248, 43			30.00
43. 00 04300 NURSERY	236, 211		236, 2	1		43.00
ANCILLARY SERVICE COST CENTERS	- F					
50.00 OPERATING ROOM	2, 517, 730	13, 434, 883	15, 952, 6		0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	801, 801	82, 417	884, 21		0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 641, 703	33, 131, 884	34, 773, 58	0. 133350	0.000000	54.00
60. 00 06000 LABORATORY	2, 852, 510	25, 012, 183			0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	365, 443	4, 920, 959	5, 286, 40	0. 368547	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	269, 415	499, 377	768, 79	0. 512271	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	94, 290	303, 135	397, 42	0. 438714	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 268, 743	6, 525, 618	8, 794, 30	0. 221580	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	304, 220	2,075,206	2, 379, 42	0. 066198	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	342, 277	5, 146, 105	5, 488, 38	0. 243616	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 630, 787	34, 370, 775	38, 001, 50	0. 205257	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0.000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 144, 872	3, 144, 8	1. 347862	0.000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	9, 982, 731	9, 982, 73	1. 107504	0.000000	88.02
90. 00 09000 CLINIC	6, 884	961, 263			0.000000	90.00
90. 01 09001 SENI OR CARE	239	2, 175, 627	2, 175, 80	0. 676478	0.000000	90.01
91.00 09100 EMERGENCY	1, 217, 713	35, 375, 478	36, 593, 19	0. 147360	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 527	2, 553, 831	2, 578, 3	0. 827841	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0		0 0.000000	0.000000	95.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	22, 822, 930	179, 696, 344	202, 519, 2	74		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	22, 822, 930	179, 696, 344	202, 519, 2	1		202.00

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COMPLIE	ATLON				COCTC	ΤO	7

In Lieu of Form CMS-2552-10

пеагиг	ritalici al Systellis P.	AREVIEW WADASH HU	SPITAL, INC.	III LI et		2002-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 3:0	epared:
			Title XIX	Hospi tal	PPS	57 pm
	Cost Center Description	PPS Inpatient Ratio 11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS	11100				
	3000 ADULTS & PEDIATRICS					30.00
	4300 NURSERY					43.00
	NCILLARY SERVICE COST CENTERS	1 1				
50.00 0	5000 OPERATING ROOM	0. 262870				50.00
51.00 0	5100 RECOVERY ROOM	0. 000000				51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	1.077307				52.00
53.00 0	5300 ANESTHESI OLOGY	0. 000000				53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 133350				54.00
60.00 0	6000 LABORATORY	0. 135179				60.00
66.00 0	6600 PHYSI CAL THERAPY	0. 368547				66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	0. 512271				67.00
68.00 0	6800 SPEECH PATHOLOGY	0. 438714				68.00
69.00 0	6900 ELECTROCARDI OLOGY	0. 221580				69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 066198				71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 243616				72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 205257				73.00
	UTPATIENT SERVICE COST CENTERS					
	8800 RURAL HEALTH CLINIC	0. 000000				88.00
	8801 RURAL HEALTH CLINIC II	1. 347862				88.01
	8802 RURAL HEALTH CLINIC III	1. 107504				88.02
	9000 CLINIC	0. 185241				90.00
	9001 SENI OR CARE	0. 676478				90.01
	9100 EMERGENCY	0. 147360				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 827841				92.00
	THER REIMBURSABLE COST CENTERS	1				
	9500 AMBULANCE SERVICES	0.000000				95.00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)					200.00
200.00	Less Observation Beds					200.00
201.00	Total (see instructions)					201.00
202.00		1				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAL DONLY Provider CCN: 15-1310 Period: For 01/01/2022 To 12/31/2022 Worksheet C Part II S726/2023 :09 pm 272/2023 :00 pm 272/202/2023 :00 pm 272/2023 :00 pm 272/2023 :00 pm 272/2023 :00 pm 272/	Health Financial Systems PA	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
Cost Center Description Total Cost (Wkst, B, Part I, col. 26) Capital Cost (Bernating Cost Net of Capital Cost (Col. 1) col. 2) Mospital Capital Cost (Cost Net of Capital Cost (Col. 1) col. 2) Departing Reduction Departing Cost Reduction ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 4,193,468 865,952 3.327,516 0 0 50.00 51.00 05000 OPERATING ROOM 4,193,468 865,952 3.327,516 0 0 51.00 52.00 05300 ANESTHESIOLOGY 0 0 0 0 52.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00 66.00 06000 LABORATORY 3,766,728 507.005 3.259,723 0 66.00 67.00 06600 PHYSI CAL THERAPY 1,948,288 177,973 1,770,315 0 66.00 68.00 066000 SPEECH PATHOLOGY 1,948,654 356,776 1,593,930 0 69.00 71.00 071000 MEDICAL SUPPLIES CHARGED TO PATIENT 1		ATIOS NET OF	Provider C	CN: 15-1310	From 01/01/2022	Part II Date/Time Pre	pared: 9 pm
CWRST. B. Part I, col. CWRST. B. Part I, col. Cost Net of Capital Cost (col. 1 - col. 2) Reduction Reduction AMCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROM 4.193,468 865,952 3.327,516 0 0 50.00 51.00 05100 RECOVERY ROM 4.037,071 816,576 3.80,117 0 52.00 52.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00 53.00 05300 ANESTHESIOLOGY 3,767,728 507,005 3,829,723 0 66.00 66.00 06000 CLABORATORY 3,766,728 507,005 3,259,723 0 66.00 67.00 0000 CLABORATORY 1,948,288 177,973 1,770,315 0 66.00 67.00 69.00 66000 ELECTROCARDI OLAGY 1.74,356 15,326 159,030 0 69.00 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 177,505 0 0 67.00 7 60.00<			Ti tl	e XIX	Hospi tal		
ANCILLARY SERVICE COST CENTERS Part 1, col. 26) Part 11 col. 26) Capit al Cost (col. 1 - col. 2) Reduction Amount ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 PERATI NG ROM 4.193,468 865,952 3,327,516 0 0 0 50.00 51.00 05100 RECOVER ROM 0 0 0 0 0 51.00 55.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 53.00 54.00 54.00 54.00 54.00 52.00 53.00 54.00 54.00 54.00 54.00 54.00 56.00 67.00 67.00 68.00 69.00 68.00 69.00 68.00 69.00 6	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
ANCILLARY SERVICE COST CENTERS 260 260 Col. 2) Amount ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 5.00 51.00 05000 (PERATINE ROM 4.193,468 865,952 3.327,516 0 0 0 50.00 52.00 05000 RDL/VERY ROM & LABOR ROOM 952,574 122,457 830,117 0 52.00 52.00 54.00 05000 RADIOLOGY-DI AGNOSTI C 4.637,071 816,576 3.820,495 0 0 66.00 66.00 066000 PHYSI CAL THERAPY 1,948,288 177,973 1,770,315 0 66.00 67.00 0000 ELECTROCARDI OLAGY 1,748,356 15,926 159,1378 0 66.00 68.00 06800 SPEECH PATHOLOGY 1,748,356 15,91,878 0 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 15,751 310,396 147,117 0 71.00 71.00<		(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0		Part I, col.	Part II col.	Capital Cos	t	Reducti on	
I. 00 2.00 3.00 4.00 5.00 MACILLARY SERVICE COST CENTERS 50.00 05000 [PERATING ROOM 4, 193, 468 865, 952 3, 327, 516 0		26)	26)			Amount	
ANCI LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM 4, 193, 468 865, 952 3, 327, 516 0							
50.00 OPERATING ROOM 4, 193, 468 865, 952 3, 327, 516 0 <td< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></td<>		1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 52.00 D5200 DELIVERY ROOM & LABOR ROOM 952.574 122.457 830,117 0 0 0 53.00 OS5400 REALESI OLOGY 0		1					
52.00 05200 DELIVERY ROOM & LABOR ROOM 952,574 122,457 830,117 0		4, 193, 468	865, 952	3, 327, 5	16 0	0	
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY DI AGNOSTI C 4, 637, 071 816, 576 3, 820, 495 0 0 54.00 60.00 0.000 LABORATORY 3, 766, 728 507, 005 3, 259, 723 0 0 60.00 66.00 0CCUPATI ONAL THERAPY 1, 948, 288 177, 973 1, 770, 315 0 66.00 67.00 06800 SPECCH PATHOLOGY 174, 356 15, 326 159, 030 0 68.00 69.00 69.00 06900 LECTROCARDI OLOGY 1, 948, 654 356, 776 1, 591, 878 0 69.00 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 337, 059 88, 243 1, 248, 816 0 0 72.00 73.00 00 73.00 00 07800 DRAUCE COST CENTERS 0 77.505 0 0 88.00 88.01 88.01 88.01 88.01 88.01 88.01 88.02 88.02 88.02 90.01 90.01 90.01 90.01 90.01		0	-		0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C 4,637,071 816,576 3,820,495 0 0 54.00 60.00 06000 LABORATORY 3,766,728 507,005 3,259,723 0 0 60.00 60.00 06000 PHYSI CAL THERAPY 1,948,288 177,973 1,770,315 0 0 66.00 60.00 06700 0CCUPATI ONAL THERAPY 393,830 33,994 359,836 0 67.00 67.00 68.00 69.00 06900 ELECTROCARDI OLOGY 174,356 15,326 159,030 0 68.00 69.00 69.00 69.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,337,059 88,243 1,248,816 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 7,800,076 740,067 7,060,009 0 72.00 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 88.02 88.02 88.02 88.02 88.02 90.00		952, 574	122, 457	830, 1	17 0	0	
60.00 06000 LABORATORY 3, 766, 728 507, 005 3, 259, 723 0 0 60.00 66.00 06600 PHYSI CAL THERAPY 1, 948, 288 177, 973 1, 770, 315 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 393, 830 33, 994 359, 836 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 174, 356 15, 326 159, 030 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 948, 654 356, 776 1, 591, 878 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 157, 513 10, 396 147, 117 0 71.00 72.00 OTZOOI IMPL DEV. CHARGED TO PATI ENTS 7, 800, 076 740, 067 7, 060, 009 0 0 73.00 00 07300 DRURAL HEALTH CLINIC 0 17, 505 0 0 88.01 88.00 0800 RURAL HEALTH CLINIC III 11, 055, 910 1, 126, 711 9, 929, 199 0 88.02 90.00 090001 SENI RO CARE 1, 471,		0	0		0 0	0	
66.00 06600 PHYSI CAL THERAPY 1,949,288 177,973 1,770,315 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 393,830 33,994 359,836 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 174,356 15,326 159,030 0 68.00 69.00 06900 ELECTROCARDIOLOGY 1,948,654 356,776 1,591,878 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 157,513 10,396 147,117 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 7,800,076 740,067 7,060,009 0 73.00 73.00 OTAGO RURAL HEALTH CLINIC LI 4,238,855 347,001 3,891,854 0 88.01 88.00 08802 RURAL HEALTH CLINIC II 11,055,910 1,126,711 9,929,199 0 88.02 90.00 09000 CLINIC 17,924 270,707 1,201,219 0 90.00 90.01 SENI ORR CARE 1,471,926 270,707 1,201,219 0 <		4, 637, 071			95 0	0	
67.00 06700 0CCUPATI ONAL THERAPY 393,830 33,994 359,836 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 174,356 15,326 159,030 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1,948,654 356,776 1,591,878 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 157,513 10,396 147,117 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,337,059 88,243 1,248,816 0 0 72.00 07300 DURGS CHARGED TO PATIENTS 7,800,076 740,067 7,060,009 0 0 73.00 00TPATIENT SERVICE COST CENTERS 0 17,505 0 0 88.00 90.00<		3, 766, 728	507,005	3, 259, 7	23 0	0	
68.00 06800 SPEECH PATHOLOGY 174,356 15,326 159,030 0 68.00 69.00 06900 ELECTROCARDIOLOGY 1,948,654 356,776 1,591,878 0 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENT 157,513 10,396 147,117 0 0 71.00 72.00 INPL. DEV. CHARGED TO PATIENTS 1,337,059 88,243 1,248,816 0 0 72.00 007300 DRUGS CHARGED TO PATIENTS 7,800,076 740,067 7,060,009 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 17,505 -17,505 0 0 88.00 88.01 88.01 08801 RURAL HEALTH CLINIC II 4,238,855 347,001 3,891,854 0 0 88.01 88.01 08802 RURAL HEALTH CLINIC III 11,055,910 1,126,711 9,29,199 0 88.01 90.00 09000 CLINIC 179,341 23,254 156,087 0 90.00 90.01 91.00 D9100 EMERGENCY 5,392,371 821,752 4,57		1, 948, 288	177, 973	1, 770, 3	15 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 1,948,654 356,776 1,591,878 0 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 157,513 10,396 147,117 0 0 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 1,337,059 88,243 1,248,816 0 0 72.00 00104 O3300 DRUGS CHARGED TO PATI ENTS 7,800,076 740,067 7,060,009 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 0 73.00 0 0 73.00 0 0 73.00 0 0 73.00 0 0 73.00 0 0 73.00 0 0 88.01 0800 RURAL HEALTH CLINIC 1 4,238,855 347,001 3,891,854 0 0 88.01 88.00 88.02 0 88.02 0 88.02 0 88.02 0 0 90.00 90.00 88.02 0 0 90.00 90.01 88.02 0 90.01 <td< td=""><td>67.00 06700 OCCUPATI ONAL THERAPY</td><td>393, 830</td><td>33, 994</td><td>359, 8</td><td>36 0</td><td>0</td><td>67.00</td></td<>	67.00 06700 OCCUPATI ONAL THERAPY	393, 830	33, 994	359, 8	36 0	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 157,513 10,396 147,117 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,337,059 88,243 1,248,816 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 7,800,076 740,067 7,060,009 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 17,505 -17,505 0 0 88.00 08800 RURAL HEALTH CLINIC 4,238,855 347,001 3,891,854 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 11,055,910 1,126,711 9,929,199 0 0 88.02 90.00 09000 CLINIC 179,341 23,254 156,087 0 0 90.00 <td< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>174, 356</td><td>15, 326</td><td>159, 0</td><td>30 0</td><td>0</td><td>68.00</td></td<>	68.00 06800 SPEECH PATHOLOGY	174, 356	15, 326	159, 0	30 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 337, 059 88, 243 1, 248, 816 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 7, 800, 076 740, 067 7, 060, 009 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 17, 505 -17, 505 0 0 88.00 88.01 88.00 08801 RURAL HEALTH CLINIC II 4, 238, 855 347, 001 3, 891, 854 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 11, 055, 910 1, 126, 711 9, 929, 199 0 0 88.02 90.00 09000 CLINIC 179, 341 23, 254 156, 087 0 90.00 90.00 90.00 09000 ENIOR CARE 1, 471, 926 270, 707 1, 201, 219 0 0 90.01 91.00 99100 EMERGENCY 5, 392, 371 821, 752 4, 570, 619 0 91.00 92.00 92.00 09200 DABSERVATI ON BEDS (NON-DI STINCT PART 2, 134, 471 378, 512 1, 755, 959 0 0 92	69. 00 06900 ELECTROCARDI OLOGY	1, 948, 654	356, 776	1, 591, 8	78 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 7,800,076 740,067 7,060,009 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 17,505 -17,505 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 17,505 -17,505 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 4,238,855 347,001 3,891,854 0 0 88.01 88.02 0802 RURAL HEALTH CLINIC III 11,055,910 1,126,711 9,929,199 0 0 88.02 90.00 09000 CLINIC 179,341 23,254 156,087 0 90.00 90.01 91.00 09100 EMERGENCY 5,392,371 821,752 4,570,619 0 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 2,134,471 378,512 1,755,959 0 0 92.00 92.00 OBSERVATION BEDS COST CENTERS 700 46 654 0 0 95.00 95.00 OPSOOLAMBULANCE SERVICES 700 46 654	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157, 513	10, 396	147, 1	17 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 17, 505 -17, 505 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 4, 238, 855 347, 001 3, 891, 854 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 11, 055, 910 1, 126, 711 9, 929, 199 0 0 88.02 90.00 09000 CLINIC 11 17, 9341 23, 254 156, 087 0 0 90.01 90.01 09010 EMIRGENCY 1, 471, 926 270, 707 1, 201, 219 0 0 90.01 91.00 09100 EMERGENCY 5, 392, 371 821, 752 4, 570, 619 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 2, 134, 471 378, 512 1, 755, 959 0 0 92.00 95.00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART 2, 134, 471 378, 512 1, 755, 959 0 0 92.00 <	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 337, 059	88, 243	1, 248, 8	16 0	0	
88.00 08800 RURAL HEALTH CLINIC 0 17,505 -17,505 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 4,238,855 347,001 3,891,854 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 11,055,910 1,126,711 9,929,199 0 0 88.02 90.00 09000 CLINIC 177,341 23,254 156,087 0 0 90.01 90.01 09010 EMIOR CARE 1,471,926 270,707 1,201,219 0 0 90.01 91.00 09100 EMERGENCY 5392,371 821,752 4,570,619 0 91.00 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2,134,471 378,512 1,755,959 0 0 92.00 07HER REI MBURSABLE COST CENTERS 700 46 654 0 0 95.00 SPECIAL PURPOSE COST CENTERS 700 46 654 0 0 200.00 201.00 200.00 200.00 200.00 200.00 200.00<	73.00 07300 DRUGS CHARGED TO PATIENTS	7, 800, 076	740, 067	7,060,0	0 0	0	73.00
88.01 08801 RURAL HEALTH CLINICII 4,238,855 347,001 3,891,854 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII 11,055,910 1,126,711 9,929,199 0 0 88.02 90.00 09000 CLINIC 1179,341 23,254 156,087 0 0 90.00 90.01 09001 SENIOR CARE 1,471,926 270,707 1,201,219 0 0 90.01 91.00 09100 EMERGENCY 5,392,371 821,752 4,570,619 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 2,134,471 378,512 1,755,959 0 0 92.00 09500 AMBULANCE SERVICES 700 46 654 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 0 0 200.00 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0	OUTPATIENT SERVICE COST CENTERS						
88.02 08802 RURAL HEALTH CLINICIII 11,055,910 1,126,711 9,929,199 0 0 88.02 90.00 09000 CLINIC 179,341 23,254 156,087 0 0 90.00 90.01 09001 SENIOR CARE 1,471,926 270,707 1,201,219 0 0 90.01 91.00 09100 EMERGENCY 5,392,371 821,752 4,570,619 0 0 91.00 92.00 OSERVATION BEDS (NON-DISTINCT PART 2,134,471 378,512 1,755,959 0 0 92.00 07HER REIMBURSABLE COST CENTERS ***********************************	88.00 08800 RURAL HEALTH CLINIC	0	17, 505	-17, 5	05 0	0	88.00
90.00 09000 CLINIC 179, 341 23, 254 156, 087 0 0 90.00 90.01 09001 SENIOR CARE 1, 471, 926 270, 707 1, 201, 219 0 0 90.01 91.00 09100 EMERGENCY 5, 392, 371 821, 752 4, 570, 619 0 0 91.00 92.00 095200 0BSERVATI ON BEDS (NON-DI STINCT PART 2, 134, 471 378, 512 1, 755, 959 0 0 92.00 07HER REI MBURSABLE COST CENTERS 700 46 654 0 0 95.00 95.00 O9500 AMBULANCE SERVICES 700 46 654 0 0 95.00 95.01 113.00 INTEREST EXPENSE 700 46, 720, 253 45, 062, 938 0 0 200.00 200.00 Subtotal (sum of lines 50 thru 199) 51, 783, 191 6, 720, 253 45, 062, 938 0 0 200.00 201.00	88.01 08801 RURAL HEALTH CLINIC II	4, 238, 855	347, 001	3, 891, 8	54 0	0	88.01
90.01 09001 SENI OR CARE 1,471,926 270,707 1,201,219 0 0 90.01 91.00 09100 EMERGENCY 5,392,371 821,752 4,570,619 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 2,134,471 378,512 1,755,959 0 0 92.00 07HER REI MBURSABLE COST CENTERS 700 46 654 0 0 95.00 95.00 09500 AMBULANCE SERVICES 700 46 654 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 1NTEREST EXPENSE 113.00 0 200.00 201.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 0 200.00 0 201.00 0 201.00 0 201.00 0 201.00 0 0 201.00 0 201.00 0 201.00<	88.02 08802 RURAL HEALTH CLINIC III	11, 055, 910	1, 126, 711	9, 929, 1	99 0	0	88.02
91.00 09100 EMERGENCY 5, 392, 371 821, 752 4, 570, 619 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 2, 134, 471 378, 512 1, 755, 959 0 0 92.00 07HER REI MBURSABLE COST CENTERS 0 0 0 92.00 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 95.00 0 0 0 0 0 95.00 0 0 0 0 95.00 0 0 0 0 95.00 0	90. 00 09000 CLINIC	179, 341	23, 254	156, 0	37 0	0	90.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 2,134,471 378,512 1,755,959 0 0 92.00 0THER REI MBURSABLE COST CENTERS 095.00 AMBULANCE SERVICES 700 46 654 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 100 113.00 113.00 113.00 113.00 113.00 0 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 0 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 201.00 0 0 201.00 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 </td <td>90. 01 09001 SENI OR CARE</td> <td>1, 471, 926</td> <td>270, 707</td> <td>1, 201, 2</td> <td>19 0</td> <td>0</td> <td>90.01</td>	90. 01 09001 SENI OR CARE	1, 471, 926	270, 707	1, 201, 2	19 0	0	90.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 700 46 654 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113.00 1NTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 200.00 200.00 201.00 Less 0bservation 95.1,783,191 6,720,253 45,062,938 0 0 200.00 201.00	91.00 09100 EMERGENCY	5, 392, 371	821, 752	4, 570, 6	19 0	0	91.00
95. 00 09500 AMBULANCE SERVICES 700 46 654 0 0 95. 00 SPECIAL PURPOSE COST CENTERS	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 134, 471	378, 512	1, 755, 9	59 0	0	92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 51, 783, 191 6, 720, 253 45, 062, 938 0 0 200.00 201.00 Less Observation Beds 2, 134, 471 378, 512 1, 755, 959 0 0 201.00	OTHER REIMBURSABLE COST CENTERS			_			
113.0011300INTEREST EXPENSE113.00200.00Subtotal (sum of lines 50 thru 199)51, 783, 1916, 720, 25345, 062, 93800200.00201.00Less Observation Beds2, 134, 471378, 5121, 755, 95900201.00	95.00 09500 AMBULANCE SERVICES	700	46	6	54 0	0	95.00
200.00 Subtotal (sum of lines 50 thru 199) 51, 783, 191 6, 720, 253 45, 062, 938 0 0 200.00 201.00 Less Observation Beds 2, 134, 471 378, 512 1, 755, 959 0 0 201.00	SPECIAL PURPOSE COST CENTERS						
201.00 Less Observation Beds 2, 134, 471 378, 512 1, 755, 959 0 0 0 201.00	113.0011300 INTEREST EXPENSE						
	200.00 Subtotal (sum of lines 50 thru 199)	51, 783, 191	6, 720, 253	45, 062, 9	38 0		
	201.00 Less Observation Beds	2, 134, 471	378, 512	1, 755, 9	59 0		
202.00 Total (line 200 minus line 201) 49,648,720 6,341,741 43,306,979 0 0 0 202.00	202.00 Total (line 200 minus line 201)	49, 648, 720	6, 341, 741	43, 306, 9	79 0	0	202.00

Health Financia	I Systems F	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS	-2552-10
CALCULATION OF REDUCTIONS FOR	OUTPATIENT SERVICE COST TO CHARGE F MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pr 5/26/2023 3:	epared: 09 pm
		-		e XIX	Hospi tal	PPS	
Cos	st Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operati ng	Part I,	Charge Rati	C		
		Cost	column 8)	(col. 6 /			
		Reduction		col. 7)			
		6.00	7.00	8.00			
	Y SERVICE COST CENTERS	1	-	1			
	ERATING ROOM	4, 193, 468	15, 952, 613				50.00
	COVERY ROOM	0	-				51.00
	LIVERY ROOM & LABOR ROOM	952, 574	884, 218				52.00
53.00 05300 ANE	ESTHESIOLOGY	0	0	0.0000	00		53.00
54.00 05400 RAD	DI OLOGY-DI AGNOSTI C	4, 637, 071	34, 773, 587	0. 1333	50		54.00
60.00 06000 LAE	BORATORY	3, 766, 728	27, 864, 693	0. 1351	79		60.00
66.00 06600 PHY	SICAL THERAPY	1, 948, 288	5, 286, 402	0.3685	47		66.00
67.00 06700 0CC	CUPATIONAL THERAPY	393, 830	768, 792				67.00
68.00 06800 SPE	EECH PATHOLOGY	174, 356	397, 425	0. 4387	14		68.00
69.00 06900 ELE	ECTROCARDI OLOGY	1, 948, 654	8, 794, 361	0. 2215	30		69.00
71.00 07100 MED	DICAL SUPPLIES CHARGED TO PATIENT	157, 513	2, 379, 426	0. 0661	78		71.00
72.00 07200 I MF	PL. DEV. CHARGED TO PATIENTS	1, 337, 059	5, 488, 382	0. 2436	16		72.00
73.00 07300 DRL	JGS CHARGED TO PATIENTS	7, 800, 076	38, 001, 562	0. 2052	57		73.00
OUTPATI EN	NT SERVICE COST CENTERS						
88.00 08800 RUR	RAL HEALTH CLINIC	0	0	0.0000	00		88.00
88.01 08801 RUR	RAL HEALTH CLINIC II	4, 238, 855	3, 144, 872	1.3478	52		88.01
88.02 08802 RUR	RAL HEALTH CLINIC III	11, 055, 910	9, 982, 731	1. 1075	04		88.02
90.00 09000 CLI	NIC	179, 341	968, 147	0. 1852	41		90.00
90.01 09001 SEN	VI OR CARE	1, 471, 926	2, 175, 866	0. 6764	78		90.01
91.00 09100 EME	ERGENCY	5, 392, 371	36, 593, 191	0. 1473	50		91.00
92.00 09200 OBS	SERVATION BEDS (NON-DISTINCT PART	2, 134, 471	2, 578, 358	0. 8278	41		92.00
OTHER REI	IMBURSABLE COST CENTERS			•			
	BULANCE SERVICES	700	0	0.0000	00		95.00
SPECIAL F	PURPOSE COST CENTERS			•			
113.00 11300 I NT							113.00
200.00 Sub	ototal (sum of lines 50 thru 199)	51, 783, 191	196, 034, 626				200.00
	ss Observation Beds	2, 134, 471					201.00
	tal (line 200 minus line 201)	49, 648, 720					202.00
				•			•

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		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 3:0	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	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	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	865, 952	15, 952, 613			26, 066	
51.00 05100 RECOVERY ROOM	0	0	0. 00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	122, 457	884, 218	0. 13849	02 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	816, 576	34, 773, 587	0. 02348	342, 515	8, 043	54.00
60. 00 06000 LABORATORY	507,005	27, 864, 693	0. 01819	673, 425	12, 253	60.00
66.00 06600 PHYSI CAL THERAPY	177, 973	5, 286, 402	0. 03366	6 126, 703	4, 266	66.00
67.00 06700 OCCUPATI ONAL THERAPY	33, 994	768, 792	0. 04421	7 80, 308	3, 551	67.00
68.00 06800 SPEECH PATHOLOGY	15, 326	397, 425	0. 03856	3 32, 079	1, 237	68.00
69.00 06900 ELECTROCARDI OLOGY	356, 776	8, 794, 361	0. 04056	588, 729	23, 884	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 396	2, 379, 426	0. 00436	9 120, 649	527	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	88, 243			78 181, 585	2, 920	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	740,067	38,001,562	0. 01947	5 873, 712	17,016	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	17, 505	0	0.00000	0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	347,001				0	88.01
88.02 08802 RURAL HEALTH CLINIC III	1, 126, 711			6 0	0	88.02
90, 00 09000 CLINIC	23, 254				65	90.00
90. 01 09001 SENI OR CARE	270, 707				0	90.01
91. 00 09100 EMERGENCY	821, 752				70	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	378, 512					
OTHER REIMBURSABLE COST CENTERS	0,0,012			1,7010	2,000	1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6, 720, 207	196, 034, 626		3, 525, 249	102, 763	
	-, -=-, 20,		1	-,, - , ,		

Health Financial Systems P	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022		pared: 9 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	-	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
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
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 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
OUTPATIENT SERVICE COST CENTERS			I			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88.02
90, 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS			I			
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 P.	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(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 15, 952, 613		
51.00 05100 RECOVERY ROOM	0	0		0 0	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 884, 218	0.00000	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 34, 773, 587	0.00000	
60. 00 06000 LABORATORY	0	0		0 27, 864, 693		60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 286, 402	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 768, 792	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 397, 425	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 8, 794, 361	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 379, 426	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 5, 488, 382	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 38, 001, 562	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 3, 144, 872	0.000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 9, 982, 731	0.00000	88. 02
90. 00 09000 CLINIC	0	0		0 968, 147	0.00000	90.00
90. 01 09001 SENI OR CARE	0	0		0 2, 175, 866		90.01
91.00 09100 EMERGENCY	0	0		0 36, 593, 191	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 578, 358	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS					•	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 196, 034, 626		200.00
			•		•	

Health Financial Systems P	ARKVIEW WABASH H	OSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/26/2023 3:0	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		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	1					
50.00 05000 OPERATI NG ROOM	0.000000	480, 184		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	342, 515		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	673, 425		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	126, 703		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	80, 308		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	32, 079		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000	588, 729		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	120, 649		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	181, 585		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	873, 712		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
90. 00 09000 CLINIC	0. 000000	2, 727		0 0	0	90.00
90. 01 09001 SENI OR CARE	0.000000	, 0		0 0	0	90.01
91.00 09100 EMERGENCY	0,000000	3, 117		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	19, 516		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	· ·		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		3, 525, 249		0 0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1310 Period: From 01/01/2022 Worksheet D For 01/01/2022 Worksheet D For 01/01/2022 Cost Center Description Cost to Charge Ratio From 01/01/2022 Title XVIII Hospital Cost Cost Cost Center Description Cost to Charge Ratio From 01/01/2022 Title XVIII Hospital Cost PS Services (se inst.) Bernol Center Description Cost Center Cost Center Description Cost Center Cest Cest Cest Cest Cest Cest Cest Cest	Health Financial Systems P.	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
Cost Center Description Cost to Charge Ratio From C, Part I, col. Cost to Charge Ratio From C, Part I, col. PPS Reimbursed Services (see inst.) Cost Reimbursed Services (see inst.) Cost Reimbursed Services (see inst.) Cost Reimbursed Services (see inst.) Reimbursed Services (sevices (sevices (sevices (sevices (sevices (sevices (sevice	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		From 01/01/2022	Part V Date/Time Pre	
Cost Center Description Cost to Charge Ratio Prom Worksheet C, 9 PPS Reimbursed Services (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. PPS Services (see inst.) Cost (see inst.) PPS Subject To Ded. & Coins. 50.00 05000 OPERATING ROM 0.262870 0 2.416.690 0 0 51.00 50.00 05000 DELICERY ROOM & LABOR ROM 0.00000 0 0 0 53.00 51.00 05000 ARDIOLOGY-DI AGNOSTI C 0.133350 0 7,172,171 0 0 54.00 66.00 066000 LABORATORY 0.135179 0 5,072,446 0 0 66.00 6000 06900 ELECTROCADIOLOGY 0.438714 0 65,740 0 0 71.00 71.00 00700 MEL DEY CHARED TO PATIENTS 0.221580 0 1,694,780 0 0<			Title	e XVIII	Hospi tal	Cost	
ANCI LLARY SERVICE COST CENTERS Charge Ratio From Worksheet C, Part I, col. Charge Ratio From Services (sec) inst.) Rel mbursed Services Subject To Ded. & Coins. Rel mbursed Services Subject To Ded. & Coins. (see inst.) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATI NG ROOM 0.262870 0 2.416.690 0 5.00 51.00 05100 (DECOVERY ROOM 8. LABOR ROOM 0.200200 0 0 0 51.00 51.00 05200 DELIVERY ROOM 8. LABOR ROOM 1.077307 0 0 0 52.00 53.00 06300 ARESTHESI OLOGY 0.000000 0 7.172.171 0 54.00 60.00 06000 LABORATORY 0.38547 0.135179 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.385471 0 132.902 0 67.00 68.00 06900 SEECH PATHOLOGY 0.438714 0 65.740 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.205257 112.817,805				Charges		Costs	
ANCI LLARY SERVICE COST CENTERS Services (see inst.) Services (see inst.) Services (see inst.) Services Not Subject To Ded. & Coins. Ded. & Sobject To Subject To Ded. & Coins. Ded. & Sobject To Ded. & Coins. Ded. & Sobject To Ded. & Coins. Ded. & Sobject To Ded. & Coins. Ded. & Coins. Ded. & Sobject To Ded. & Coins. Ded. & Coins. Ded. & Sobject To Ded. & Coins. Ded. & Coin	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
ANCI LLARY SERVICE COST CENTERS Operating of the second seco		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
Part I. col. Ded. & Coins. Ded. & Coins. Openant 9 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0		From	Services (see	Servi ces	Services Not		
9 (see inst.) (see inst.) (see inst.) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 0.262870 0 2.416.690 0 0 0 50.00 51.00 05100 RCOVERY ROOM 0.000000 0 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.077307 0 0 0 0 52.00 53.00 05300 AMESTHESI OLOGY 0.000000 0 0 0 52.00 54.00 05400 RADIOGO-DATORY 0.135179 0 5.072,446 0 0 66.00 66.700 0CG700 CCUPATI ONAL THERAPY 0.512271 1.301,372 0 0 66.00 67.00 06700 DECCRAPTIOLOGY 0.438714 0 65,740 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.2612271 0		Worksheet C,	inst.)	Subject To	Subject To		
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51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.077307 0 0 0 0 52.00 53.00 05200 REDIVERY ROOM & LABOR ROOM 1.07307 0 0 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.133350 0 7,172,171 0 0 54.00 60.00 06000 LABORATORY 0.135179 0 5,072,446 0 66.00 60.00 06000 LABORATORY 0.368547 0 1,301,372 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.512271 0 132,902 0 67.00 68.00 08600 SPEECH PATHOLOGY 0.221580 0 1,694,780 0 68.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.243616 717,627 0 72.00 73.00 O300 RURAL HEALTH CLINIC TH 88.01 88.01 88.01 88.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
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54.00 05400 RADI OLOGY-DI AGNOSTI C 0.133350 0 7, 172, 171 0 0 54.00 60.00 06000 LABORATORY 0.135179 0 5, 072, 446 0 0 60.00 61.00 06000 PHYSI CAL THERAPY 0.368547 0 1, 301, 372 0 0 66.00 62.00 06700 OCUPATI ONAL THERAPY 0.512271 0 132, 902 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 0 65, 740 0 0 68.00 69.00 OPODO ELECTROCARDI OLOGY 0.221580 0 1, 694, 780 0 0 71.00 0 72.00 0 71.00 0 72.00 0 72.00 0 72.00 0 72.00 0 72.00 0 72.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 90.00 90.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01	52.00 05200 DELIVERY ROOM & LABOR ROOM	1.077307	C		0 0	0	52.00
60.00 06000 LABORATORY 0.135179 0 5,072,446 0 0 60.00 66.00 06600 PHYSI CAL THERAPY 0.368547 0 1.301,372 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.512271 0 132,902 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 0 65,740 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 0 1,694,780 0 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 72.00 72.00 72.00 72.00 <	53. 00 05300 ANESTHESI OLOGY	0. 000000	C		0 0	0	53.00
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67.00 06700 0CCUPATI ONAL THERAPY 0.512271 0 132,902 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 0 65,740 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 0 1,694,780 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.066198 0 310,024 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 0 717,627 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.205257 0 12,817,805 74 0 73.00 00000 DUTPATI ENT SERVICE COST CENTERS 0 258,030 0 0 90.00 90.00 88.00 88.00 88.00 08802 RURAL HEALTH CLINIC III 88.01 88.00 90.01 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 9	60. 00 06000 LABORATORY	0. 135179	C	5, 072, 44	6 0	0	60.00
68.00 06800 SPEECH PATHOLOGY 0.438714 0 65,740 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 0 1,694,780 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.066198 0 310,024 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 0 71.627 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.205257 0 12,817,805 74 0 73.00 0UTPATI ENT SERVICE COST CENTERS 0.205257 0 12,817,805 74 0 73.00 88.00 08801 RURAL HEALTH CLINIC 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 90.00 0 90.00 0 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 90.01 90.00 90.00 90.01 90.00 90.00 90.01 90.01 90.01 90.01 90.01 90.	66. 00 06600 PHYSI CAL THERAPY	0. 368547	C	1, 301, 37	2 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0.221580 0 1,694,780 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.066198 0 310,024 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 717,627 0 0 72.00 73.00 07000 RUGS CHARGED TO PATIENTS 0.205257 0 12,817,805 74 0 73.00 00TPATIENT SERVICE COST CENTERS 0 205257 0 12,817,805 74 0 73.00 88.00 08801 RURAL HEALTH CLINIC 11 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 90.00 90000 CLINIC 88.00 90.01 90.01 90.01 90.01<	67.00 06700 OCCUPATI ONAL THERAPY	0. 512271	C	132, 90	2 0	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.066198 0 310,024 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 717,627 0 0 72.00 00 07300 DRUGS CHARGED TO PATIENTS 0.205257 0 12,817,805 74 0 73.00 0UTPATIENT SERVICE COST CENTERS 0 0.205257 0 12,817,805 74 0 73.00 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 90.00 90000 CLINIC 0.185241 0 258,030 0 0 90.00 <td< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>0. 438714</td><td>C</td><td>65, 74</td><td>0 0</td><td>0</td><td>68.00</td></td<>	68.00 06800 SPEECH PATHOLOGY	0. 438714	C	65, 74	0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 717,627 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.205257 0 12,817,805 74 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.205257 0 12,817,805 74 0 73.00 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 89.01 90.00 90.00 90.00 90.00 90.00 90.00	69. 00 06900 ELECTROCARDI OLOGY	0. 221580	C	1, 694, 78	0 0	0	69.00
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OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.00 88.01 88.02 08802 RURAL HEALTH CLINIC II 88.01 88.01 80.00 09000 CLINIC 0 258,030 0 0 90.00 09000 SENIOR CARE 0.676478 0 238,127 0 0 90.01 91.00 09100 EMERGENCY 0.147360 0 6,945,707 13,150 0 91.00 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0.827841 0 563,282 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 39,706,703 13,224 0 200.00 200.00 200.00 201.00 201.00 201.00		0. 243616	C	717, 62	7 0	0	72.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.00 88.01 88.02 08802 RURAL HEALTH CLINIC II 88.01 88.01 80.00 09000 CLINIC 0 258,030 0 0 90.00 09000 SENIOR CARE 0.676478 0 238,127 0 0 90.01 91.00 09100 EMERGENCY 0.147360 0 6,945,707 13,150 0 91.00 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0.827841 0 563,282 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0.000000 0 39,706,703 13,224 0 200.00 200.00 200.00 201.00 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 205257	C C	12, 817, 80	5 74	0	73.00
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88.02 08802 RURAL HEALTH CLINICIII 88.02 88.02 90.00 09000 CLINIC 0.185241 0 258,030 0 90.00 90.01 09001 SENIOR CARE 0.676478 0 238,127 0 0 90.01 91.00 09100 EMERGENCY 0.147360 0 6,945,707 13,150 0 91.00 92.00 09SERVATION BEDS (NON-DISTINCT PART 0.827841 0 563,282 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 0 39,706,703 13,224 0 200.00 200.00 Subtotal (see instructions) 0 39,706,703 13,224 0 200.00 201.00 Usages 0 0 39,706,703 13,224 0 201.00	88.00 08800 RURAL HEALTH CLINIC						88.00
90.00 09000 CLINIC 0.185241 0 258,030 0 90.00 90.00 90.01 09001 SENIOR CARE 0.676478 0 238,127 0 0 90.01 91.00 09100 EMERGENCY 0.147360 0 6,945,707 13,150 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.827841 0 563,282 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 000000 39,706,703 13,224 0 200.00 200.00 Subtotal (see instructions) 0 39,706,703 13,224 0 200.00 201.00 201.00	88.01 08801 RURAL HEALTH CLINIC II						88.01
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91.00 09100 EMERGENCY 0.147360 0 6,945,707 13,150 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.827841 0 563,282 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 0.000000 0 0 95.00 95.00 Subtotal (see instructions) 0 39,706,703 13,224 0 200.00 201.00 201.00 0 0 0 201.00 201.00 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 2	90. 00 09000 CLINIC	0. 185241	C C	258, 03	0 0	0	90.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.827841 0 563,282 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0.000000 0 95. 00 95. 00 9500 AMBULANCE SERVICES 0 0 0 95. 00 200. 00 201. 00 13, 224 0 200. 00 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 </td <td>90. 01 09001 SENI OR CARE</td> <td>0. 676478</td> <td>C</td> <td>238, 12</td> <td>7 0</td> <td>0</td> <td>90.01</td>	90. 01 09001 SENI OR CARE	0. 676478	C	238, 12	7 0	0	90.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 39, 706, 703 13, 224 0 200.00 200.00 Subtotal (see i nstructions) 0 39, 706, 703 13, 224 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00	91.00 09100 EMERGENCY	0. 147360	C	6, 945, 70	7 13, 150	0	91.00
95. 00 09500 AMBULANCE SERVICES 0.000000 0 95. 00 95. 00 200. 00 Subtotal (see instructions) 0 39, 706, 703 13, 224 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 0 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 827841	C	563, 28	2 0	0	92.00
200.00 Subtotal (see instructions) 0 39,706,703 13,224 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00	OTHER REIMBURSABLE COST CENTERS	·					1
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00	95.00 09500 AMBULANCE SERVICES	0. 000000			0		95.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00	200.00 Subtotal (see instructions)		c c	39, 706, 70	3 13, 224	0	200.00
Only Charges							201.00
			с	39, 706, 70	3 13, 224	0	202.00

Health Financial Systems PA	RKVI EW WABASH	HOSPITAL. INC.		In Lie	」of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-1310	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/26/2023 3:0	epared:
		Title	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 OFERATING ROOM	635, 275	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	956, 409	0				54.00
60. 00 06000 LABORATORY	685, 688	0				60.00
66.00 06600 PHYSI CAL THERAPY	479, 617	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	68, 082	0				67.00
68.00 06800 SPEECH PATHOLOGY	28, 841	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	375, 529	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	20, 523	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	174, 825	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 630, 944	15	i l			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
90. 00 09000 CLINIC	47, 798	0				90.00
90. 01 09001 SENI OR CARE	161, 088	0				90.01
91.00 09100 EMERGENCY	1, 023, 519	1, 938				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	466, 308	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	7, 754, 446	1, 953				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	7, 754, 446	1, 953	5			202.00

Health Financial Systems PA	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-1310	Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
		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	:	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	1		1	- 1		
30. 00 ADULTS & PEDIATRICS	1, 169, 677					•
43.00 NURSERY	26, 276		26, 27			•
200.00 Total (lines 30 through 199)	1, 195, 953		1, 172, 30	4, 589		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	(00	col. 6)	-			
INDATIENT DOUTINE CEDVICE COST CENTERS	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	50	14.024	1			1 20 00
30. 00 ADULTS & PEDIATRICS	58					30.00
43.00 NURSERY	4	973				43.00
200.00 Total (lines 30 through 199)	62	15, 807	1			200.00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		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	Date/Time Pre 5/26/2023 3:0	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	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	r	-	1			
50.00 05000 OPERATI NG ROOM	865, 952	15, 952, 613				
51.00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	122, 457	884, 218			57	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	816, 576	34, 773, 587	0. 02348	60, 523	1, 421	54.00
60. 00 06000 LABORATORY	507,005	27, 864, 693	0. 01819	116, 201	2, 114	60.00
66.00 06600 PHYSI CAL THERAPY	177, 973	5, 286, 402	0. 03366	4, 820	162	66.00
67.00 06700 OCCUPATI ONAL THERAPY	33, 994	768, 792	0. 04421	7 2, 798	124	67.00
68.00 06800 SPEECH PATHOLOGY	15, 326	397, 425	0. 03856	2, 364	91	68.00
69.00 06900 ELECTROCARDI OLOGY	356, 776	8, 794, 361	0. 04056	9 47, 973	1, 946	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 396	2, 379, 426	0. 00436	6, 302	28	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	88, 243	5, 488, 382	0. 01607	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	740, 067	38, 001, 562	0. 01947	72, 120	1, 405	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	17, 505	0	0. 00000	0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	347, 001	3, 144, 872	0. 11033	9 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	1, 126, 711	9, 982, 731	0. 11286	06 0	0	88.02
90. 00 09000 CLINIC	23, 254	968, 147	0. 02401	9 456	11	90.00
90. 01 09001 SENI OR CARE	270, 707	2, 175, 866	0. 12441	3 0	0	90.01
91.00 09100 EMERGENCY	821, 752	36, 593, 191	0. 02245	6 101, 397	2, 277	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	378, 512	2, 578, 358	0. 14680	5, 011	736	92.00
OTHER REIMBURSABLE COST CENTERS	•		•			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	6, 720, 207	196, 034, 626		456, 615	12, 339	200. 00

Health Financial Systems	PARKVI EW WABASH I			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE ()THER PASS THROUGH COS		F	Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre 5/26/2023 3:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	5	Adjustments		Educati on	
	Adj ustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	S		•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)					
	4.00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 48	1 0.00	58	30.00
43. 00 04300 NURSERY		0	108	0.00	4	43.00
200.00 Total (lines 30 through 199)		0	4, 589			200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTER						
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
	6					

Health Financial Systems F	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	pared: 9 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	-	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
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	l o		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l o		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			I		I	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88.02
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	0	92.00
OTHER REIMBURSABLE COST CENTERS		ı		- 1		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
	-	-	1	1	-	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1310 Period: From 01/01/2022 To 12/31/2022 Worksheet D Date/Time Prepared: 5/26/2023 3: 09 pm Date/Time Prepared: 5/26/2023 3: 09 pm Total Cost Cost Center Description All Other Medical Education Cost Total Cost (sum of cost 4) Total Cost (sum of Cost 4) Total Cost (sum of cost 4) Total Cost (sum of cost 4) Total Cost (sum of cost 4) 0	Health Financial Systems P	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
Cost Center Description All Other Medical Education Total Cost (sum of cost Cost Total Cost (sum of cost cols, 2, 3, and 4) Total Charges (col, 5, 2, and 4) Total Charges (col, 5, 2, and 4) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 (DPERATING ROOM 0 0 0 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0.000000 52.00 05200 (DPERATING ROOM 0 0 0 0.000000 51.00 53.00 05300 (APETATINE SILLORY 0 0 0 0 0.000000 52.00 54.00 05300 (LIVERY ROOM & LABOR ROOM 0 0 0 0.000000 53.00 54.00 06600 (LABORATORY 0 0 0 0 0.000000 64.00 0 0.000000 64.00 0 0.000000 64.00 0.000000 64.00 0.000000 64.00 0.000000 64.00 0.000000 64.00 0.000000 64.00 0.000000 </td <td></td> <td>RVICE OTHER PAS</td> <td></td> <td></td> <td>From 01/01/2022 To 12/31/2022</td> <td>Part IV Date/Time Pre</td> <td>pared: 9 pm</td>		RVICE OTHER PAS			From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	pared: 9 pm
Medical Education Sum of cols. (2, 3, and 4) Outpatient (5, 0, 2, 3, and 4) (From Wist. Col. 8) (From Wist. (col. 5 + col. 7) (col. 5 + col. 7) 4.00 5.00 6.00 7.00 8.00 50.00 05000 (PERATING ROOM 0 0 0 0.000000 51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0.000000 51.00 52.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 52.00 0.000000 51.00 0.000000 51.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 60.00 0.000000 60.00			Ti tl	e XIX			
Education Cost 1, 2, 3, and 4) Cost (sum of cols. 2, 3) and 4) C, Part I, col. 8) (col. 5 + col. 7) ANCILLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 (PERATING ROOM 0 0 0 0 0.000000 8.00 50.00 05100 (RCOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0.000000 51.00 52.00 0.000000 51.00 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0 0 0 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0.000000 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td>Cost Center Description</td> <td></td> <td>Total Cost</td> <td>Total</td> <td>Total Charges</td> <td>Ratio of Cost</td> <td></td>	Cost Center Description		Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4) col s. 2, 3, and 4) col . 8) col . 7) (see instructions) 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATING ROOM 0 0 0 0.000000 51.00 05000 0PERATING ROOM 0 0 0 0.000000 51.00 52.00 05200 DELIVEY ROOM & LABOR ROOM 0 0 0 0.000000 51.00 52.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 53.00 66.00 066000 LABORATORY 0 0 0 27.864.693 0.000000 66.00 66.00 OG6000 DECOVERT PATHENAL THERAPY 0 0 0 7.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 0 0 7		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000000 51.00 51.00 0.000000 51.00 0.000000 51.00 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 51.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 52.00 0.000000 64.00 0.000000 64.00 0.000000 66.00 0.000000 66.00 0.000000 68.00 0.0		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,		
ACI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 50.00 05000 0PERATING ROM 0 0 0 15,952,613 0.000000 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0.000000 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 0 0 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 27.864,693 0.000000 54.00 60.00 06600 PHYSI CAL THERAPY 0 0 0 7.864,693 0.000000 66.00 0 68.00 66.00<		Cost	4)		col. 8)		
4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVI CE COST CENTERS				and 4)			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DPERATI NG ROM 0 0 0 0.000000 50.00 51. 00 05100 RCOVERY ROOM 0 0 0.000000 51.00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0.000000 52.00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 54. 00 OS400 RAD IOGY-DI AGNOSTI C 0 0 0 34.773,587 0.000000 54.00 60. 00 66000 PHYSI CAL THERAPY 0 0 0 27.864,693 0.000000 66.00 66.00 67.00 COPUPATI IONAL THERAPY 0 0 0 7.00 6700 0COPATI IONAL THERAPY 0 0 0 397,425 0.000000 68.00 68.00 69.00 1.00 0 397,425 0.000000 69.00 71.00 0 0 2.379,426 0.0000000 72.00 73.00 0							
50.00 05000 OPERATING ROOM 0 0 15, 952, 613 0, 000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 52.00 DELIVERY ROOM & LABOR ROOM 0 0 0 0.000000 52.00 52.00 DS200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 53.00 53.00 05400 RABITHESI OLOGY 0 0 0 0.000000 53.00 54.00 05400 RABITHESI OLOGY 0 0 0 0.000000 54.00 60.00 CABORATORY 0 0 0 27,864,693 0.000000 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 768,792 0.000000 68.00 68.00 SPEECH PATHOLOGY 0 0 0 397,425 0.000000 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 2,379,426 0.000000 71.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 </td <td></td> <td>4.00</td> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td></td>		4.00	5.00	6.00	7.00	8.00	
51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 52.00 05200 DELLYERY ROOM & LABOR ROOM 0 0 0 884, 218 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 52.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 0 34, 773, 587 0.000000 64.00 60.00 06000 LABORATORY 0 0 0 27, 864, 693 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 73, 587 0.000000 67.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 768, 792 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 2, 379, 426 0.000000 69.00 72.00 O7200 I MPL DEV CHARGED TO PATI ENTS 0 0 0 38, 001, 562 0.000000 73.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 884,218 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 54.00 OS400 RADI OLOGY-DI AGNOSTI C 0 0 0 34,773,587 0.000000 54.00 60.00 06000 LABORATORY 0 0 27,864,693 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 5,286,402 0.000000 66.00 67.00 0C700 OCUPATI ONAL THERAPY 0 0 0 397,425 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 8,794,361 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 2,379,426 0.000000 71.00 72.00 07200 IMPL. DV. CHARGED TO PATIENTS 0 0 0 3,144,872 0.000000 88.00 88.01 08800 RURAL HEALTH CLINIC II 0 0 0 9,982,7		0	0		0 15, 952, 613		
53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 34, 773, 587 0.000000 54.00 60.00 06000 LABORATORY 0 0 0 27, 864, 693 0.000000 60.00 66.00 06000 LABORATORY 0 0 0 5, 266, 402 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 5, 266, 402 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 397, 425 0.000000 68.00 69.00 07300 RUPL ES CHARGED TO PATI ENT 0 0 2, 379, 426 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 38, 001, 562 0.000000 72.00 73.00 07300 DURGS CHARGED TO PATI ENTS 0 0 0 0 0.000000 88.00 88.01 08800 RURAL HEALTH CLINI C II 0		0	0		0 0		
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 34, 773, 587 0.000000 54.00 60.00 06000 LABORATORY 0 0 0 27, 864, 693 0.000000 60.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 5, 286, 402 0.000000 66.00 67.00 0C0UPATI ONAL THERAPY 0 0 0 768, 792 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 37, 425 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 8, 794, 361 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 38, 001, 562 0.000000 71.00 73.00 07200 I MPL DEV. CHARGED TO PATI ENTS 0 0 0 38, 001, 562 0.000000 72.00 73.00 08807 RURAL HEALTH CLINIC II 0 0 0 0.000000 88.00 88.00 08802 RURAL HEALTH CLINIC III 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 884, 218</td> <td></td> <td></td>		0	0		0 884, 218		
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	200.00 Total (lines 50 through 199)	0	0		0 196, 034, 626		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1310 Period: From 01/01/2022 To 12/31/2022 Part IV Date/Time Prepared: 5/26/2023 3:09 pm Cost Center Description Outpatient Ratio of Cost to Charges (Col. 6 + col. 7) Inpatient Program Carges Outpatient Program Cost Center Description Outpatient Program Col. 7) Inpatient Program Carges Outpatient Program Cast Center Description Dotototototototototototototo	Health Financial Systems P	ARKVIEW WABASH H	OSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges (col. 6) Inpatient Program Pass-Through Costs (col. 8) Outpatient Program Charges Outpatient Program Pass-Through Costs (col. 9) Outpatient Program Charges ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 50.00 50.00 05000 OPERATING ROOM 0.000000 36,236 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 414 0 0 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 414 0 0 53.00 60.00 06000 LABORATORY 0.000000 60.523 0 0 0 53.00 60.00 06000 LABORATORY 0.000000 2.798 0 0 66.00 69.00 06000 CLABORATORY 0.000000 2.798 0 0 66.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 4.7973 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES		RVICE OTHER PASS	Provider C		From 01/01/2022	Part IV Date/Time Pre	
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67.00 06700 0CCUPATI ONAL THERAPY 0.000000 2,798 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 2,364 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 47,973 0 0 69.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 6,302 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 6 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 72,120 0 0 73.00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 0 0 0 88.01 88.01 08801 RURAL HEALTH CLINI C II 0.000000 0 0 88.01 88.01 08802 RURAL HEALTH CLINI C III 0.000000 0 0 0 88.01 88.01 09000 CLINI C 0.000000 0 0 0 0 0 90.00 90.00 09000 CLINI C 0.00000	60. 00 06000 LABORATORY	0. 000000	116, 201		0 0	0	60.00
68.00 06800 SPEECH PATHOLOGY 0.000000 2,364 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 47,973 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 6,302 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 72.00 73.00 D7300 DRUGS CHARGED TO PATIENTS 0.000000 72,120 0 0 0 72.00 0007200 RURAL HEALTH CLINIC 0.000000 72,120 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.00 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 0 0 0 90.00 <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0. 000000</td> <td>4, 820</td> <td></td> <td>0 0</td> <td>0</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 820		0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0.00000 47,973 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 6,302 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 72.00 73.00 D7300 DRUGS CHARGED TO PATIENTS 0.000000 72,120 0 0 0 73.00 00TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.01 88.02 08002 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 90100 ENIOR CARE 0.000000 0 0 0 0 9	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 798		0 0	0	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 6,302 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 72,120 0 0 0 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.01 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.00 90.01 90.01 90.01 90.01 90.01 90.01	68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 364		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72,120 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 0 0 0 88.02 90.10 09001 SENIOR CARE 0.000000 0 0 0 90.01 90.01 91.00 09100 EMERGENCY 0.000000 101,397 0 0 91.00 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5,011 0 0 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 9	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	47, 973		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.00000 72,120 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.00000 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.00000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.00000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.00000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 456 0 0 90.00 90.10 09001 SENIOR CARE 0.000000 101,397 0 0 90.01 91.00 09100 EMERGENCY 0.000000 101,397 0 0 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5,011 0 0 92.00 01HER REIMBURSABLE COST CENTERS 95.00 95.00 95.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 302		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 0 0 0 88.00 88.02 08802 RURAL HEALTH CLINIC II 0.000000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 456 0 0 90.00 90.01 09001 SENIOR CARE 0.000000 0 0 90.01 90.01 91.00 09100 EMERGENCY 0.000000 101, 397 0 0 91.00 92.00 95.00 95.0	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 0 0 0 88.01 88.02 08002 RURAL HEALTH CLINIC III 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 456 0 0 90.00 90.01 09001 SENI OR CARE 0.000000 0 0 90.00 91.00 09100 EMERGENCY 0.000000 101, 397 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5, 011 0 0 92.00 074HER REIMBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	72, 120		0 0	0	73.00
88.01 08801 RURAL HEALTH CLINICII 0.00000 0 0 0 88.01 88.02 08802 RURAL HEALTH CLINICIII 0.000000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 456 0 0 90.00 90.01 09001 SENIOR CARE 0.00000 0 0 0 90.01 91.00 09100 EMERGENCY 0.000000 101,397 0 0 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5,011 0 0 92.00 071HER REIMBURSABLE COST CENTERS 95.00 95.00 95.00 95.00 95.00 95.00	OUTPATIENT SERVICE COST CENTERS						
88.02 08802 RURAL HEALTH CLINICIII 0.00000 0 0 0 88.02 90.00 09000 CLINIC 0.000000 456 0 0 90.00 90.01 09000 SENIOR CARE 0.000000 0 0 0 90.01 91.00 09100 EMERGENCY 0.000000 101,397 0 0 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 5,011 0 0 92.00 074HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
90.00 09000 CLINIC 0.00000 456 0 0 90.00 90.01 09001 SENIOR CARE 0.00000 0 0 0 90.01 91.00 09100 EMERGENCY 0.00000 101,397 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.00000 5,011 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
90. 01 09001 SENI OR CARE 0.000000 0 0 0 90. 01 91. 00 09100 EMERGENCY 0.000000 101, 397 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 5, 011 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00	88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
91.00 09100 EMERGENCY 0.000000 101,397 0 0 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 5,011 0 0 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 5,011 0 0 95.00	90. 00 09000 CLINIC	0. 000000	456		0 0	0	90.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.00000 5,011 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	90. 01 09001 SENI OR CARE	0. 000000	0		0 0	0	90.01
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0. 000000	101, 397		0 0	0	91.00
95.00 09500 AMBULANCE SERVICES 95.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	5, 011		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
200,00 Total (Lines 50 through 199) 456,615 0 0 0/200,00	95.00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		456, 615		0 0	0	200.00

	ARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2022 To 12/31/2022		
		Ti †I	e XIX	Hospi tal	PPS	⁷⁷ pili
			Charges	nospi tui	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Servi ces (see		Servi ces Not	(000 1101)	
	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	
ANCI LLARY SERVI CE COST CENTERS	•	•	•			
50.00 05000 OPERATING ROOM	0. 262870	0		0 201, 010	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.077307	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. 133350	0		0 333, 095	0	54.00
60. 00 06000 LABORATORY	0. 135179	0		0 340, 271	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 368547	0		0 13, 942	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 512271	0		0 2,606	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 438714	0		0 12, 991	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 221580	0		0 62, 960	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 066198	0		0 28, 578	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 243616	0		0 48, 996	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 205257	0		0 88, 708	0	73.00
OUTPATIENT SERVICE COST CENTERS			•			1
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
90. 00 09000 CLINIC	0. 185241	0		0 6, 319	0	90.00
90. 01 09001 SENI OR CARE	0. 676478	0		0 89, 249	0	90.01
91.00 09100 EMERGENCY	0. 147360	0		0 675, 092	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 827841			0 51, 124		92.00
OTHER REIMBURSABLE COST CENTERS	·	·	•			1
95. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
200.00 Subtotal (see instructions)		0		0 1, 954, 941	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 1, 954, 941	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-1310 Period: From 01/01/2022 Worksheet D From 01/01/2022 Title XIX Hospital PPS Provider CON: 15-1310 Provide	Health Financial Systems PA	ARKVI EW WABASH	HOSPITAL, INC.		In Lieu	u of Form CMS-	2552-10
Cost Center Description Cost S Cost Reinbursed Services Subject To Ded. & Coins. Reinbursed Services Not Subject To Subject Cost Centres Subject To Subject Cost Centres Subject To Subject Cost Centres Subject Cost Centres Subtotat Clas	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1310	From 01/01/2022	Part V Date/Time Pre	
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Subject To Ded. & Coins. (see inst.) Cost Reimbursed Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 50.00 51.00 50.00 50.00 51.00 50.00 52.00 53.00 53.00 53.00 53.00 53.00 53.00 54.00 60.00 66.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 <t< td=""><td></td><td></td><td>Ti tl</td><td>e XIX</td><td>Hospi tal</td><td></td><td>•</td></t<>			Ti tl	e XIX	Hospi tal		•
Reimbursed Services Subject To Ded. & Coins. Reimbursed Services Subject To Ded. & Coins. Services Not Subject To Ded. & Coins. ANCI LLARY SERVICE COST CENTERS (see inst.) (see inst.) (see inst.) 6.00 7.00 7.00 50.00 51.00 50.00 05000 (PEATI NG ROOM 0 0 52.00 52.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 51.00 05000 (PEATI NG ROOM 0 0 0 53.00 54.00 05000 RADI CLOCY DI AGNOSTI C 0 44.418 54.00 60.00 06000 LABORATORY 0 5.138 66.00 60.00 06900 SPEECH PATHOLOGY 0 5.4599 68.00 61.00 06900 SPEECH PATHOLOGY 0 13.951 69.00 71.00 07100 MEDI CLAL SUPPLIES CHARGED TO PATI ENTS 0 11.936 72.00 72.00 0720 DRVL SCHARGED TO PATI ENTS 0 11.936 72.00 72.00 0720 DRVLS CHARGED TO PATI ENTS 0 11.936 72.00 <td></td> <td>Cos</td> <td>sts</td> <td></td> <td></td> <td></td> <td></td>		Cos	sts				
Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) 50.00 05000 (PERATI NG ROOM 0 7.00 50.01 05000 (DECOVERY ROOM 0 0 51.00 05100 RECOVERY ROOM 0 0 52.00 05200 OLIVERY ROOM & LABOR ROOM 0 0 53.00 05300 AleSTHESIOLOCY 0 0 54.00 05400 RADI OLOCY-DI ARNOSTI C 0 44, 418 00000 LABORATORY 0 5, 138 66.00 66.00 06600 SPECCH PATHOLOCY 0 5, 699 66.00 66.00 06600 SPECCH PATHOLOCY 0 1, 325 67.00 69.00 06900 ELECTROCARD IOLOGY 0 1, 892 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 11, 936 72.00 73.00 00000 RUGSC HARGED TO PATI ENTS 0 11, 936 72.00 73.00 00000 RUGSC HARGED TO PATI ENTS 0 11, 736 73.00 0010 PARCE RUTAL H	Cost Center Description	Cost	Cost				
ANCI LLARY SERVICE COST CENTERS Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) 6.00 7.00 7.00 50.00 50.00 50.00 50.00 05000 (PERATING ROOM 0 0 50.00 51.00 51.00 05100 (RCOVERY ROOM 0 0 0 52.00 52.00 05200 (RAUPERV ROOM & LABOR ROOM 0 0 53.00 53.00 54.00 05400 (RADI OLGY-DI ASNOSTI C 0 44,418 54.00 54.00 60.00 06000 (LABORATORY 0 5,997 60.00 66.00 60.00 06700 (OCCUPATI ONAL THERAPY 0 5,138 67.00 61.00 06700 (DCCUPATI ONAL THERAPY 0 13.951 71.00 71.00 07100 (MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 13.951 69.00 72.00 07300 (DRUS CHARGED TO PATI ENTS 0 18.208 72.00 73.00 0800 RURAL HEALTH CLINI C 11 88.00 88.01 88.00 88.01 0880		Reimbursed	Reimbursed				
Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 (PERATING ROOM 0 51.00 05100 (RECOVERY ROOM 0 52.00 05300 ALESTHESI OLOGY 0 53.00 05300 ALESTHESI OLOGY 0 60.00 0 0 54.00 05300 ALESTHESI OLOGY 0 60.00 06000 LABORATORY 0 44, 418 60.00 06000 LABORATORY 0 5, 338 66.00 0 66.00 7, 00 60.00 06600 SPEECH PATHOLOGY 0 5, 699 68.00 06600 SPEECH PATHOLOGY 0 5, 699 69.00 06600 SPEECH PATHOLOGY 0 13, 951 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 13, 951 70.00 07300 DEVIGS CHARED TO PATIENTS 0 11, 936 72.00 07300 DEVIGS CHARED TO PATIENTS 0 18, 208 0UTPATIENT SERVICE COST CENTERS 0 18, 208<		Servi ces	Services Not				
Image: Inst.) (see inst.)							
ANCI LLARY SERVICE COST CENTERS 50.00 05000 (DPERTING ROOM 0 52,839 50.00 51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 05300 ANESTHESI OLOGY 0 0 52.00 54.00 05400 RADI OLOGY DI AGNOSTI C 0 44,418 54.00 60.00 06000 LABORATORY 0 45,997 66.00 66.00 05700 OCCUPATI ONAL THERAPY 0 1,335 67.00 66.00 6600 SPEECH PATHOLOGY 0 1,3951 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 13,951 67.00 68.00 06600 SPEECH PATHOLOGY 0 5,699 68.00 69.00 06900 ELECTROCARDI OLOGY 0 13,951 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 18,208 72.00 007200 IMPL DEV. CHARGED TO PATI ENTS 0 18,208 73.00 00100 MERCAL HEALTH CLINI		Ded. & Coins.	Ded. & Coins.				
ANCILLARY SERVICE COST CENTERS 0 50.00 OSCOOL S0.00 DEFRATING ROOM 0 50.00 S0.00							
50.00 05000 0PERATING R00M 0 52,839 50.00 51.00 05100 RECOVERY R00M 0 0 0 52.00 05100 RECOVERY R00M 0 0 0 53.00 05300 ANESTHESI 0LOGY 0 0 0 53.00 54.00 05400 RDI OLOGY-DI AGNOSTI C 0 44,418 54.00 60.00 06600 LABORATORY 0 44,997 66.00 60.00 06600 LHERAPY 0 5,138 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1,335 67.00 68.00 06800 SPECH PATHOLOGY 0 1,892 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 11,936 72.00 73.00 07300 DRUSC CHARGED TO PATIENTS 0 11,936 73.00 73.00 08801 RURAL HEALTH CLINIC 88.01 88.01 88.01 88.01 08802 RURAL HEALTH CLINIC III 90.01 90.01 90.01 90.00 090		6.00	7.00				
51.00 05100 RECOVERY ROOM 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53.00 OS200 ALESTHESI DLOGY 0 0 53.00 54.00 05400 RADI DLOGY-DLAGNOSTI C 0 44,418 54.00 60.00 06000 LABORATORY 0 45,997 60.00 61.00 06000 LABORATORY 0 1,335 67.00 62.00 06000 LABORATORY 0 1,335 67.00 68.00 06000 DELICRCARDI DLOGY 0 1,335 67.00 68.00 06000 ELETROCARDI DLOGY 0 1,3951 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1,936 72.00 73.00 OT200 I MPL. DEV. CHARGED TO PATI ENTS 0 18,208 73.00 0017010 MEDI CAL SUPPLIES CONT CENTERS 0 1,171 88.00 88.00 08801 RURAL HEALTH CLINIC 11 88.01 88.01 88.01 08802 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05300 RADIOLOGY-DI AGNOSTI C 0 44.418 54.00 60.00 06000 LABORATORY 0 45,997 60.00 66.00 06600 PHYSI CAL THERAPY 0 5,138 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 1,335 67.00 68.00 06900 ELECTROCARDI OLOGY 0 1,982 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1,982 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 11,936 72.00 73.00 DIUPATI ENT SERVICE COST CENTERS 88.00 88.01 88.01 88.01 88.00 08800 RURAL HEALTH CLINIC III 88.02 90.00 90.00 90.00 90.01 OPOOL SENI OR CARE 0 1,171 90.00 90.00 90.01 90.01 90.01 91.00 99.00 99.00 99.0	50.00 05000 OPERATING ROOM	0	52, 839				50.00
53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 44, 418 54.00 60.00 CABORATORY 0 45, 997 66.00 66.00 66.00 OCCUPATI ONAL THERAPY 0 5, 138 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 335 67.00 68.00 OSECH PATHOLOGY 0 1, 335 67.00 68.00 69.00 OGOO LABORTORY 0 13, 951 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 73.00 019.936 73.00 73.00 73.00 73.00 73.00 73.00 73.00 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.01 88.02 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	51.00 05100 RECOVERY ROOM	0	0				51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 44,418 54.00 60.00 06000 LABORATORY 0 45,997 60.00 66.00 067.00 0CCUPATIONAL THERAPY 0 5,138 67.00 67.00 06600 PHYSI CAL THERAPY 0 1,335 67.00 68.00 06800 SPEECH PATHOLOGY 0 1,335 67.00 69.00 DEDICAL SUPPLIES CHARGED TO PATIENT 0 1,892 71.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11,936 72.00 73.00 DUTPATIENT SERVICE COST CENTERS 0 18,208 73.00 08800 RURAL HEALTH CLINIC II 88.00 88.01 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.01 80.02 08802 RURAL HEALTH CLINIC III 88.01 80.0 09000 CLINIC 0 1,171 90.00 90.01 90001 SENIOR CARE 0 60,375 90.01 91.00 09000 SERVATION BEDS (NON-DISTINCT PART 0 42,323	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
60.00 06000 LABORATORY 0 45, 997 60.00 66.00 06600 PHYSI CAL THERAPY 0 5, 138 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 335 67.00 68.00 06800 SPEECH PATHOLOGY 0 5, 699 68.00 69.00 06900 ELECTROCARDI OLOGY 0 13, 951 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 11, 936 72.00 72.00 O7200 I MPL. DEV. CHARGED TO PATI ENTS 0 18, 208 73.00 007300 DRUGS CHARGED TO PATI ENTS 0 18, 208 73.00 00TFATI ENT SERVICE COST CENTERS 0 1, 171 88.01 88.01 88.01 088001 RURAL HEALTH CLINIC III 88.01 88.01 88.02 088002 RURAL HEALTH CLINIC III 88.01 90.01 90.01 O9000 CLINIC 0 1, 171 88.02 90.01 09000 CLINIC 0 1, 171 90.01 91.00 09000 CLINIC <td>53.00 05300 ANESTHESI OLOGY</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td>53.00</td>	53.00 05300 ANESTHESI OLOGY	0	0				53.00
66.00 06600 PHYSI CAL THERAPY 0 5, 138 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1, 335 67.00 68.00 06800 SPEECH PATHOLOGY 0 5, 699 68.00 69.00 06900 ELECTROCARDI OLOGY 0 13, 951 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1, 892 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 11, 936 72.00 00TPATIENT SERVICE COST CENTERS 0 18, 208 72.00 73.00 88.00 08800 RURAL HEALTH CLINIC 88.00 88.00 88.00 88.01 08802 RURAL HEALTH CLINIC II 88.01 88.02 90.00 90.01 09001 SENIOR CARE 0 60, 375 90.01 90.01 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 42, 323 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 404, 764 200.00 200.00 200.00 200.00 200.00	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	44, 418				54.00
67.00 06700 0CCUPATI ONAL THERAPY 0 1,335 67.00 68.00 06800 SPEECH PATHOLOGY 0 5,699 68.00 69.00 06900 ELECTROCARDI OLOGY 0 13,951 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 1,892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 11,936 72.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0 18,208 73.00 0UTPATI ENT SERVICE COST CENTERS 0 1,171 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC III 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.01 90.00 09000 CLINIC 0 1,171 90.00 90.01 09000 SENIOR CARE 0 60,375 91.00 90.01 91.00 OP100 EMEGENCY 0 42,323 92.00 92.00 92.00 00100	60. 00 06000 LABORATORY	0	45, 997				60.00
68.00 06800 SPEECH PATHOLOGY 0 5, 699 68.00 69.00 06900 ELECTROCARDI OLOGY 0 13, 951 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 1, 892 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 11, 936 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 18, 208 73.00 0UTPATI ENT SERVICE COST CENTERS 0 1, 171 88.01 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 08801 RURAL HEALTH CLINIC III 88.01 88.02 09000 CLINIC 0 1, 171 90.00 09000 CLINIC 90.00 90.01 91.00 09100 EMERGENCY 0 1, 171 90.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 42, 323 91.00 92.00 09200 MBULANCE SERVICES 0 404, 764 200.00 200.00 200.00 Subtotal (see instructions) 0 404, 764 200.00 </td <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0</td> <td>5, 138</td> <td></td> <td></td> <td></td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0	5, 138				66.00
69.00 06900 ELECTROCARDI OLOGY 0 13,951 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1,892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 11,936 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 18,208 73.00 0UTPATI ENT SERVICE COST CENTERS 0 18,208 73.00 0UTPATI ENT SERVICE COST CENTERS 0 1,171 88.00 88.01 08801 RURAL HEALTH CLINIC II 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.01 88.02 0802 RURAL HEALTH CLINIC III 88.01 90.01 09001 SENIOR CARE 0 60,375 90.01 90.01 09100 EMERGENCY 0 99,482 91.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 42,323 92.00 01HER REIMBURSABLE COST CENTERS 0 404,764 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	67.00 06700 OCCUPATI ONAL THERAPY	0	1, 335				67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 1,892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 11,936 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 18,208 73.00 0UTPATIENT SERVICE COST CENTERS 0 18,208 73.00 000 08800 RURAL HEALTH CLINIC II 88.00 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.02 90.00 09000 CLINIC 0 1,171 90.01 09010 SENIOR CARE 0 60,375 90.00 90.01 09100 EMERGENCY 0 99,482 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 42,323 92.00 01HER REI MBURSABLE COST CENTERS 0 404,764 200.00 200.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 404,764 201.00 201.00 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>0</td> <td>5, 699</td> <td></td> <td></td> <td></td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	0	5, 699				68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 1,892 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 11,936 72.00 73.00 07000 DRUGS CHARGED TO PATIENTS 0 18,208 73.00 0UTPATIENT SERVICE COST CENTERS 0 18,208 73.00 0UTPATIENT SERVICE COST CENTERS 0 11,936 73.00 88.00 08800 RURAL HEALTH CLINIC II 88.01 88.01 08801 RURAL HEALTH CLINIC II 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.01 90.01 09000 CLINIC 0 1,171 90.00 90.01 09010 SENIOR CARE 0 60,375 90.01 90.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 42,323 92.00 07HER REI MBURSABLE COST CENTERS 0 404,764 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 404,764 200.00 201.00	69.00 06900 ELECTROCARDI OLOGY	0	13, 951				69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 18,208 73.00 0UTPATIENT SERVICE COST CENTERS 88.00 88.00 88.00 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC 88.00 88.01 88.01 88.01 08802 RURAL HEALTH CLINIC II 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.01 90.00 09000 CLINIC 0 1,171 90.00 09000 SENIOR CARE 0 60,375 91.00 09100 EMERGENCY 0 99,482 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 42,323 92.00 0 09200 OBSERVATION SEDS (NON-DI STINCT PART 0 42,323 92.00 0 09200 OBSERVATION SEDS (NON-DI STINCT PART 0 42,323 92.00 0 09200 Subtotal (see instructions) 0 404,764 200.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 892				71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.01 88.02 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 936				72.00
OUTPATI ENT SERVICE COST CENTERS 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.01 88.02 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01	73.00 07300 DRUGS CHARGED TO PATIENTS	0	18, 208				73.00
88.01 08801 RURAL HEALTH CLINICII 88.01 88.02 08802 RURAL HEALTH CLINICIII 88.02 90.00 09000 CLINIC 0 1,171 90.01 09001 SENIOR CARE 0 60,375 90.01 91.00 09100 EMERGENCY 0 99,482 91.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 0THER REI MBURSABLE COST CENTERS 0 404,764 200.00 200.00 201.00 Subtotal (see instructions) 0 404,764 200.00 201.00							
88.02 08802 RURAL HEALTH CLINICIII 88.02 90.00 09000 CLINIC 0 1,171 90.00 90.01 09001 SENIOR CARE 0 60,375 90.01 91.00 09100 EMERGENCY 0 99,482 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 0THER REIMBURSABLE COST CENTERS 0 404,764 200.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 Only Charges 0 0 201.00	88.00 08800 RURAL HEALTH CLINIC						88.00
90.00 09000 CLINIC 0 1,171 90.00 90.01 09001 SENIOR CARE 0 60,375 90.01 91.00 09100 EMERGENCY 0 99,482 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 0THER REI MBURSABLE COST CENTERS 0 95.00 95000 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 201.00 Uses PBP Clinic Lab. Services-Program 0 201.00 201.00 201.00 201.00	88.01 08801 RURAL HEALTH CLINIC II						88.01
90.00 09000 CLINIC 0 1,171 90.00 90.01 09001 SENIOR CARE 0 60,375 90.01 91.00 09100 EMERGENCY 0 99,482 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 0THER REI MBURSABLE COST CENTERS 0 95.00 95000 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 201.00 Uses PBP Clinic Lab. Services-Program 0 201.00 201.00 201.00 201.00	88.02 08802 RURAL HEALTH CLINIC III						88.02
90.01 09001 SENIOR CARE 0 60, 375 90.01 91.00 09100 EMERGENCY 0 99, 482 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 42, 323 92.00 0THER REI MBURSABLE COST CENTERS 0 95.00 9500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 0 404, 764 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201		0	1, 171				
91.00 09100 EMERGENCY 0 99,482 91.00 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0 92.00 95.00 95.00 Subtotal (see instructions) 0 404,764 200.00 200.00 201.00 201.00 101 y Charges 0 404,764 201.00 <		0					
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 42,323 92.00 0THER REI MBURSABLE COST CENTERS 0 95.00 95.00 95.00 95.00 95.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 0 404,764 200.00 201.00		0					
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00							
95.00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 0 404,764 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00		-	,				
200.00 201.00Subtotal (see instructions)0404,764200.00201.00 0nl y Charges00201.00		0					95.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0		0					
Only Charges		0					
		0	404, 764				202.00

Health Financial Systems

PARKVI EW	WABASH	HOSPI TAL,	INC.

In Lieu of Form CMS-2552-10

COMPUT	Financial Systems PARKVIEW WABASH H	OSPITAL, INC.	In Lieu	u of Form CMS-2	2552-1
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Peri od:	Worksheet D-1	
			From 01/01/2022		
			To 12/31/2022		
				5/26/2023 3:0	9 pm
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I – ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	ays, excluding newborn)		4, 590	1.00
2.00	Inpatient days (including private room days, excluding swind	g-bed and newborn days)		4, 481	2.00
3.00	Private room days (excluding swing-bed and observation bed of		private room davs.	0	3.0
	do not complete this line.	5			
4.00	Semi-private room days (excluding swing-bed and observation	bed days)		3, 001	4.0
5.00	Total swing-bed SNF type inpatient days (including private r		or 21 of the cost	89	5.0
). 00	reporting period	thi bugit becen	bel 31 01 the cost	07	3.0
00		and dave) ofter December	21 of the east	0	6.0
5.00	Total swing-bed SNF type inpatient days (including private r	oolii days) arter beceniber	31 OF the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	20	7.0
	reporting period				
3.00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable	to the Program (excludin	ng swing-bed and	927	9.00
	newborn days) (see instructions)				
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	31	10.0
	through December 31 of the cost reporting period (see instru	uctions)	3,		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII		room davs) after	0	11.0
	December 31 of the cost reporting period (if calendar year,				-
12.00	Swing-bed NF type inpatient days applicable to titles V or >		ate room days)	0	12.0
	through December 31 of the cost reporting period			-	
13.00	Swing-bed NF type inpatient days applicable to titles V or >	(IX only (including prive	ate room days)	0	13.0
5.00	after December 31 of the cost reporting period (if calendar			0	15.0
4.00	Medically necessary private room days applicable to the Proc			0	14.0
	Total nursery days (title V or XIX only)	gram (excruding swing-bed	i uays)	0	14.0
16.00	Nursery days (title V or XIX only)			0	16.0
	SWING BED ADJUSTMENT		- · · · · · · · · · · · · · · · · · · ·		
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17.0
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	f the cost		18.0
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	ces through December 31 d	of the cost	250.44	19.0
	reporting period	0			
20.00	Medicaid rate for swing-bed NF services applicable to service	ces after December 31 of	the cost	250.44	20.0
	reporting period				
21.00	Total general inpatient routine service cost (see instruction	ons)		6, 595, 921	21.0
	Swing-bed cost applicable to SNF type services through Decen		ting period (line		22.0
.2.00	5 x line 17)		ting period (inte	Ű	22.0
23.00	Swing-bed cost applicable to SNF type services after December	ar 31 of the cost reporti	na period (line A	0	23.0
13.00	x line 18)		ng period (inne d	0	23.0
04 00	,	on 21 of the post margar	ing ported (list	5,009	24.0
24.00	Swing-bed cost applicable to NF type services through Decemb	ber 31 of the cost report	ing period (ine	5,009	24.0
	7 x line 19)			_	
25.00	Swing-bed cost applicable to NF type services after December	s of the cost reportin	ig perioa (line 8	0	25.0
	x line 20)				
26.00	Total swing-bed cost (see instructions)			133, 366	
27.00	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		6, 462, 555	27.0
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-b	ped and observation bed o	charges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)			0	29.0
				0	30.0
	Semi-private room charges (excluding swing-bed charges)				
80.00		7 ÷ line 28)		0, 000000	31.0
0. 00 1. 00	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
0.00 1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	·		0.00	32.0
80.00 81.00 82.00 83.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4))	uctions)	0. 00 0. 00	32. 0 33. 0
30.00 31.00 32.00 33.00 34.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m) minus line 33)(see instru	uctions)	0.00 0.00 0.00	32.0 33.0 34.0
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l) minus line 33)(see instru ine 31)	uctions)	0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0
30.00 31.00 32.00 33.00 34.00 35.00 36.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)) minus line 33)(see instru ine 31))		0.00 0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0 36.0
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line $29 \div line 3$) Average semi-private room per diem charge (line $30 \div line 4$) Average per diem private room charge differential (line 32 ± 1 Average per diem private room cost differential (line 34×1 Private room cost differential adjustment (line 3×1 ine 35) General inpatient routine service cost net of swing-bed cost) minus line 33)(see instru ine 31))		0.00 0.00 0.00 0.00 0.00 0	32.0 33.0 34.0 35.0 36.0
30.00 31.00 32.00 33.00 34.00 35.00 36.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)) minus line 33)(see instru ine 31))		0.00 0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0 36.0
30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 34 × l Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ninus line 33)(see instru ine 31)) t and private room cost c		0.00 0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0 36.0
80.00 81.00 82.00 83.00 84.00 85.00 86.00 87.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ninus line 33)(see instru ine 31)) t and private room cost c		0.00 0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0 36.0
30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 34 × l Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ninus line 33)(see instru ine 31) t and private room cost o DJUSTMENTS		0.00 0.00 0.00 0.00 0.00	32.0 33.0 34.0 35.0 36.0 37.0
30.00 31.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 38.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 34 × l Average per diem private room cost differential (line 34 × l Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	ninus line 33)(see instru ine 31) t and private room cost o DJUSTMENTS ee instructions)		0.00 0.00 0.00 0.00 6,462,555	32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0
30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 m Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL Adjusted general inpatient routine service cost per diem (see	minus line 33)(see instru ine 31) t and private room cost o DUSTMENTS ee instructions) ne 38)		0.00 0.00 0.00 6,462,555 1,442.21	32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0

Program 2.00 NURSERY Intensis 3.00 INTENSI 4.00 CORONAR 5.00 BURN IN 5.00 SURGICA 6.00 SURGICA 6.00 SURGICA 7.00 SURGICA 7.00 SURGICA 8.00 Program 7.00 Total P PASS THI 111) 7.00 Total P medical TARGET A 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Continu 55.01, S3) are 8.00 Medicar 1.00 <th>Cost Center Description Y (title V & XIX only)</th> <th>Total Inpatient Cost</th> <th>Title Total Inpatient</th> <th></th> <th>From 01/01/2022 To 12/31/2022 Hospi tal</th> <th></th> <th></th>	Cost Center Description Y (title V & XIX only)	Total Inpatient Cost	Title Total Inpatient		From 01/01/2022 To 12/31/2022 Hospi tal		
Program 2.00 NURSERY Intensis 3.00 INTENSI 4.00 CORONAR 5.00 BURN IN 5.00 SURGICA 6.00 SURGICA 6.00 SURGICA 7.00 SURGICA 7.00 SURGICA 8.00 Program 7.00 Total P PASS THI 111) 7.00 Total P medical TARGET A 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Continu 55.01, S3) are 8.00 Medicar 1.00 <th>Y (title V & XIX only)</th> <th>Inpatient Cost</th> <th>Total</th> <th>1</th> <th></th> <th></th> <th></th>	Y (title V & XIX only)	Inpatient Cost	Total	1			
Program 2.00 NURSERY Intensis 3.00 INTENSI 4.00 CORONAR 5.00 BURN IN 5.00 SURGICA 6.00 SURGICA 6.00 SURGICA 7.00 SURGICA 7.00 SURGICA 8.00 Program 7.00 Total P PASS THI 111) 7.00 Total P medical TARGET A 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Target 7.00 Continu 55.01, S3) are 8.00 Medicar 1.00 <th>Y (title V & XIX only)</th> <th>Inpatient Cost</th> <th>Total</th> <th>1</th> <th></th> <th></th> <th>// piii</th>	Y (title V & XIX only)	Inpatient Cost	Total	1			// piii
Intensif 3.00 INTENSI 4.00 CORONAR 5.00 BURN IN 6.00 BURN IN 5.00 Program 7.00 Total P PASS THI Pass th 1111 .00 0.00 Total P medical TARGET 1.00 Total P medical TARGET 1.00 Total P medical Target 1.00 Target 1.00 Target 1.00 Terded 1.00 Expecte market .00 1.00 Relief 2.00 Total M CAI Justructor .00 3.00 Medicar 1.00 Total M CAI Inwab PROGRAM			Days	Diem (col. 1 ÷ col. 2)	1	Program Cost (col. 3 x col. 4)	
Intensif 3.00 INTENSI 4.00 CORONAR 5.00 BURN IN 6.00 BURN IN 5.00 Program 7.00 Total P PASS THI Pass th 1111 .00 0.00 Total P medical TARGET 1.00 Total P medical TARGET 1.00 Total P medical Target 1.00 Target 1.00 Target 1.00 Terded 1.00 Expecte market .00 1.00 Relief 2.00 Total M CAI Justructor .00 3.00 Medicar 1.00 Total M CAI Inwab PROGRAM		1.00	2.00	3.00	4.00	5.00	42.
I. 00 CORONAR 0.00 BURN IN 0.00 SURGICA 0.00 SURGICA 0.00 OTHER S 0.00 Toral P PASS THI 0.00 Total P 0.00 Total P 0.00 Total P 0.00 Total P 0.01 Persane 0.02 Adjustm 0.00 Target 0.00 Target 0.00 Trended updated Updated 0.00 Relief 0.00 Total M CAI Iowab PROGRAM 0.00 Total M CAH, se CO 0.00 Total M CAH, se CO 0.00 Total M CAH, se CO	ive Care Type Inpatient Hospital Units						
2.00 OTHER S 2.00 Program 3.01 Program 3.00 Program 0.00 Total P PASS THI PASS THI 0.00 Pass th 1111) .00 0.00 Pass th 1111) .00 0.00 Total P medical Program 0.00 Total P medical Program 0.00 Total P medical Program 0.00 Target 0.00 Adjustm 0.00 Target 0.00 Bonus p 0.00 Expecte market .00 0.00 Relief 0.00 Relief 0.00 Relief 0.00 Medicar instruc .00 0.00 Total M CAH, se .00 0.00 Total M 0.01 Total Y	SIVE CARE UNIT IRY CARE UNIT NTENSIVE CARE UNIT						43. 44. 45.
Col 3.00 Program 3.01 Program 3.00 Program 0.00 Total P PASS THI PASS THI 0.00 Pass th 1111 .00 0.00 Pass th 1111 .00 0.00 Pass th 1111 .00 2.00 Total P medical TARGET J 1.00 Program 0.00 Target 0.00 Target 0.00 Target 0.00 Trended updated Do 0.00 Expecte market .00 0.00 Relief 1.00 Medicar instruc .00 0.00 Total M CAH, se .00 1.00 Total M CAH, se .00 1.00 Total M CAH, se .00 0.00	CAL INTENSIVE CARE UNIT SPECIAL CARE (SPECIFY)						46. 47.
B. 01 Program Total P PASS THI 0.00 Pass th 111 . .00 Pass th and IV . .00 Total P .00 Pass th and IV . .00 Total P .00 Target .00 Target .00 Trended .00 Trended .00 Trended .00 Trended .00 Continu .00 Relief .00 Medicar instruc .00 .00 Total M .00 Fite V	Cost Center Description	ŀ				1.00	
D. 00 Total P PASS THI 0.00 Pass th 111) .00 0.00 Pass th and IV) .00 2.00 Total P 3.00 Target 3.00 Ternded 4.00 Program 5.01 Permane 5.02 Adj ustm 7.00 Trended updated 00 0.00 Continu 55.01, 53) are enter z 20.00 0.00 Relief 0.00 Medicar instruc 5.00 0.00 Total M CAH, se 00 0.00 Total M CAH, se 00 0.00 </td <td>m inpatient ancillary service cost (Wks</td> <td>st. D-3, col. 3</td> <td>, line 200)</td> <td></td> <td></td> <td>1.00</td> <td>48.</td>	m inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			1.00	48.
0.00 Pass th 111) .00 .00 Pass th .00 Pass th .00 Pass th .00 Total P .00 Total P .00 Total P .00 Total P .00 Target .01 Permane .02 Adjustm .00 Target .00 Reverte market .00 .00 Relief .00 Relief .00 Redicar .00 Total M .00 Total M .00 Total M .00 Total M .00 Skilled .00 Skilled .00 R	m inpatient cellular therapy acquisitic Program inpatient costs (sum of lines 4	on cost (Worksh	eet D-6, Part		, column 1)	0 2, 080, 902	48.
.00 Pass th and IV) 2.00 Total P medical TARGET J 1.00 Program 5.00 Target 5.00 Target 6.01 Permane 6.02 Adjustm 6.01 Permane 6.02 Adjustm 6.00 Target 7.00 Differe 8.00 Bonus p 9.00 Trended updated enter z 9.00 Relief 9.00 Relief 9.00 Medicar instruc instruc 9.00 Title V (line 1 No 7.00 Title V (line 1 PART II 9.00 Skilled 9.00 Redical 100 Title V (line 1 PART II 9.00 Redical 10.00 Skilled 11.00 Skilled 12.00 Total M 13.00 Title V 14.00	HROUGH COST ADJUSTMENTS hrough costs applicable to Program inpa	atient routine	services (from	n Wkst. D, su	m of Parts I and	0	50.
2.00 Total P medical A.00 Total P medical TARGET J Program A.00 Program A.00 Program A.00 Target B.00 Target B.00 Target B.00 Target B.00 Tended updated Do D.00 Expecte B.00 Relief B.00 Medicar instruc So B.00 Total M CAH, se O Co Total M CAH, se O D.00 Skilled O0 Adjuste D.00 Relief D.00 Skilled O0 Capital D.00 Capital <tr< td=""><td>hrough costs applicable to Program inpa N</td><td>atient ancillar</td><td>y services (fi</td><td>rom Wkst. D,</td><td>sum of Parts II</td><td>0</td><td>51.</td></tr<>	hrough costs applicable to Program inpa N	atient ancillar	y services (fi	rom Wkst. D,	sum of Parts II	0	51.
TARGET .00 Program .00 Target .01 Permane .02 Adjustm .00 Target .00 Differe .00 Differe .00 Differe .00 Trended .00 Trended .00 Continu .55.01, 53) are .00 Relief .00 Relief .00 Medicar instruc Nedicar .00 Title V .00 Title V .00 Total M .00 Skilled .00 Redical .00 Total M .00 Total M .00 Redical .00 Total M .00 Redical .00 Skilled .00 Redical .00 Redical .00 Redical .00 Redic	Program excludable cost (sum of lines 5 Program inpatient operating cost exclud	ling capital re	lated, non-phy	ysician anest	hetist, and	0	
5.00 Target 5.01 Permane 5.02 Adjustm 5.00 Target 7.00 Differe 8.00 Bonus p 9.00 Trended updated updated 9.00 Trended updated 00 9.00 Expecte 9.00 Relief 9.00 Relief 9.00 Relief 9.00 Medicar 100 Title V (line 1 13.00 Title V (line 1 9.00 Skilled 9.00 Redical 9.00 Total M CAH, se 00 9.00 Total M 00 Adjust 00 Relief 00 Relief 00 Title V (line 1 P 00 Relief 00 Relief 00 Catl K <	Il education costs (line 49 minus line 5 AMOUNT AND LIMIT COMPUTATION	52)					
6.01 Permane 6.02 Adjustm 6.00 Target 7.00 Differe 8.00 Bonus p 9.00 Trended updated 0.00 9.00 Expecte market 0.00 9.00 Expecte market 0.00 9.00 Relief 9.00 Relief 9.00 Redicar 1.00 Medicar 1.00 Medicar 1.00 Total M CAH, se 0.00 1.00 Total M CAH, se 0.00 1.00 Total M CAH, se 0.00 9.00 Redical 1.00 Total M 0.00 Redical 1.00 Skilled 0.00 Redical 1.00 Capital 2.00 Program 3.00 Inpatie 2.00 Program	m discharges : amount per discharge					0.00	
 .02 Adjustm .00 Target .00 Differe .00 Differe .00 Trended updated .00 Expecte market .00 Continu .53) are enter z .00 Relief .00 Allowab <u>PROGRAM</u> .00 Medicar instruc .00 Total M CAH, se .00 Title V (line 1 .00 Total t <u>PART II</u> .00 Skilled .00 Total Program .00 Capital .00 Program .00 Inpatie .00 Aggrega 	nent adjustment amount per discharge					0.00	
.00Differe.00Differe.00Bonus p.00Trended.00Expectemarket.00.00Continu.55.01,.53) are.00Relief.00Relief.00Medicarinstruc.00.00Medicar.00Total M.00Title V.00Title V.00Title V.00Skilled.00Adjuste.00Redical P.00Skilled.00Total P.00Capital.00Program.00Nedical.00Redical.01Redical.02Redical <td>ment amount per discharge (contractor u</td> <td>use only)</td> <td></td> <td></td> <td></td> <td>0.00</td> <td></td>	ment amount per discharge (contractor u	use only)				0.00	
00Bonus p00Trendedupdated00Expectemarket00Continu55.01,53) areenter z00Relief00AllowabPROGRAM00Medicarinstruc00Total MCAH, se00Title V(line 100Total tPART II00Skilled00Total P00Capital26, lin00Program00Inpatie00Inpatie	amount (line 54 x sum of lines 55, 55.					0	
00Trended updated00Expecte market00Continu 55.01, 53) are enter z00Relief00AllowabPROGRAM00Medicar instruc00Medicar instruc00Total M CAH, se00Title V (line 100Total M CAH, se00Total M CAH, se00Total M CAH, se00Total M CAH, se00Total M CAH, se00Total M CAH, se00Total T PART II00Skilled00Program O Medical00Program O Program00Inpatie 0 Aggrega	rence between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00Expecte market00Continu55.01, 53) are enter z00Relief00AllowabPROGRAM00Medicar instruc00Medicar instruc00Medicar instruc00Total M CAH, se00Title V (line 100Title V (line 100Skilled00Adjuste00Program 0000Capital 26, lin00Program 0000Program 0000Program 0000Inpatie 0000Aggrega	payment (see instructions) ed costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	
00Continu 55.01, 53) are enter z00Relief00AllowabPROGRAM00Medicar 	ed and compounded by the market basket) red costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year (cost report,	updated by the	0.00	60
00Relief00AllowabPROGRAM00Medicarinstruc00Medicarinstruc00Total MCAH, se00Title V(line 100Total tPART II00Skilled00Program00Capital00Program00Program00Program00Program00Inpatie00Inpatie	nuous improvement bonus payment (if line or line 59, or line 60, enter the less re less than expected costs (lines 54 x	ser of 50% of t	he amount by w	which operati	ng costs (line	0	61
PROGRAM OMedicar instruc OMedicar instruc OMEDICAR	zero. (see instructions) ⁵ payment (see instructions) while instructions)	nt (coo instru	ations)			0	62 63
instruc Medicar instruc Total M CAH, se CO Title V (line 1 Title V (line 1 Total t PART II CO Skilled CO Adjuste CO Program CO Capital 26, lin CO Program CO Program CO Program	ble Inpatient cost plus incentive payme M INPATIENT ROUTINE SWING BED COST						
instruc CAH, see Title V (line 1 OU Title V (line 1 OU Title V (line 1 OU Total t PART II OU Skilled OU Adjuste OU Program OU Medical OU Total P OU Capital 26, lin OU Program OU Program OU Inpatie OU Aggrega	re swing-bed SNF inpatient routine cost ctions)(title XVIII only)	Ũ		·		44, 709	
CAH, se Title V (line 1 Title V (line 1 Total t PART II OO Skilled OO Adjuste OO Program OO Medical OO Capital 26, lin OO Program OO Program OO Program	re swing-bed SNF inpatient routine cost ctions)(title XVIII only) Medicare swing-bed SNF inpatient routin					44, 709	65
.00Title V (line 1 Total t PART II.00Skilled double.00Skilled double.00Adjuste Program Om Medical 26, lin 26, lin 00.00Per die e 00.00Per die e 00.00Program e duble.01Per die e 00.02Program e duble.03Per die e duble.04Program e duble.05Program e duble.06Program e duble.07Inpatie e duble.08Aggrega	see instructions V or XIX swing-bed NF inpatient routine			, .	5.		67
00Total t PART II00Skilled00Adjuste00Program00Medical00Total P00Capital26, lin00Program00Program00Inpatie00Aggrega	12 x line 19) V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68
PART II 00 Skilled 00 Adjuste 00 Program 00 Medical 00 Total P 00 Capital 26, lin 00 Per die 00 Program 00 Inpatie 00 Aggrega	13 x line 20) title V or XIX swing-bed NF inpatient r	routine costs (line 67 + line	e 68)		0	69
00Adjuste00Program00Medical00Total P00Capital26, lin00Per die00Program00Inpatie00Aggrega	II - SKILLED NURSING FACILITY, OTHER NU ed nursing facility/other nursing facili				<u>,</u>		70
 00 Program 00 Medical 00 Total P 00 Capital 26, lin 00 Per die 00 Program 00 Inpatie 00 Aggrega 	ed general inpatient routine service co	2			,	1	71
00 Total P 00 Capital 26, lin 00 Per die 00 Program 00 Inpatie 00 Aggrega	m routine service cost (line 9 x line 7	71)					72
00 Capital 26, lin 00 Per die 00 Program 00 Inpatie 00 Aggrega	Illy necessary private room cost applica	0	•			l	73
00 Per die 00 Program 00 Inpatie 00 Aggrega	Program general inpatient routine servi il-related cost allocated to inpatient r				Part II, column		74 75
00 Inpatie 00 Aggrega	em capital-related costs (line 75 ÷ lin						76
00 Aggrega	m capital-related costs (line 9 x line					l	77
55 5	ent routine service cost (line 74 minus		rovi der record	ds)		l	78
00 Total P					nus line 79)	1	80
	pate charges to beneficiaries for excess Program routine service costs for compa	arison to the c		, · · - ····		l	81
	ate charges to beneficiaries for excess					,	82
	pate charges to beneficiaries for excess Program routine service costs for compa ent routine service cost per diem limit ent routine service cost limitation (li	tation ne 9 x line 81)				
	pate charges to beneficiaries for excess Program routine service costs for compa ent routine service cost per diem limit ent routine service cost limitation (li mable inpatient routine service costs (s	tation ne 9 x line 81 see instruction)				83
.00 Total P	pate charges to beneficiaries for excess Program routine service costs for compa ent routine service cost per diem limit ent routine service cost limitation (li mable inpatient routine service costs (s m inpatient ancillary services (see ins	tation ne 9 x line 81 see instruction structions)) s)				83 84
. 00 Total o	pate charges to beneficiaries for excess Program routine service costs for compa ent routine service cost per diem limit ent routine service cost limitation (li mable inpatient routine service costs (s	ation ne 9 x line 81 see instruction structions) (see instructio of lines 83 th) s) ns)				83

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	pared: 9 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, 134, 471	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	1, 169, 677	6, 595, 921	0. 17733	3 2, 134, 471	378, 512	90.00
91.00 Nursing Program cost	0	6, 595, 921	0.00000	0 2, 134, 471	0	91.00
92.00 Allied health cost	0	6, 595, 921	0.00000	0 2, 134, 471	0	92.00
93.00 All other Medical Education	0	6, 595, 921	0.00000	2, 134, 471	0	93.00

Health Financial Systems

PARKVI EW	WABASH	HOSPI TAL,	INC.

In Lieu of Form CMS-2552-10

	Financial Systems PARKVIEW WABASH HC			J of Form CMS-2	
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Period: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre	
				5/26/2023 3:0)9 pm
	Cast Captar Description	Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed da			4, 590	
	Inpatient days (including private room days, excluding swing			4, 481	
	Private room days (excluding swing-bed and observation bed d	lays). If you have only p	private room days,	0	3.
	do not complete this line. Semi-private room days (excluding swing-bed and observation	bod dave)		3, 001	4.
	Total swing-bed SNF type inpatient days (including private r		per 31 of the cost	3,001	
. 00	reporting period	com days) through becom		0,	0.
. 00	Total swing-bed SNF type inpatient days (including private r	room 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 ro	oom days) through Decembe	er 31 of the cost	20	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private ro	an dave) after December	21 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line)	Join days) after becember	ST OF THE COST	0	0.
. 00	Total inpatient days including private room days applicable	to the Program (excludin	ng swing-bed and	58	9.
	newborn days) (see instructions)		5 - 5		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.
1 00	through December 31 of the cost reporting period (see instru				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or X		ate room days)	0	12.
	through December 31 of the cost reporting period			-	
3.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.
	after December 31 of the cost reporting period (if calendar				
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	gram (excluding swing-bed	d days)	0	14.
	Nursery days (title V or XIX only)			4	
	SWING BED ADJUSTMENT				1 10.
	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17.
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.
9.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 (of the cost	250.44	19
	reporting period				
0.00	Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of	the cost	250.44	20.
1 00	reporting period			(EOE 001	21
	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		sting period (line	6, 595, 921 0	1
2.00	5 x line 17)	iber 51 01 the cost repor	ting period (inte	0	22.
3. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reporti	ng period (line 6	0	23.
	x line 18)				
4.00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ting period (line	5,009	24.
5 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reportin	a pariod (line 9	0	25.
5.00	x line 20)	ST OF the cost reportin	ig period (inne o	0	25.
6.00	Total swing-bed cost (see instructions)			133, 366	26.
	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26))	6, 462, 555	27.
0.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	bed and observation bed o	charges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
1	Average per diem private room charge differential (line 32 m		uctions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		differential (line	0 6, 462, 555	
1.00	27 minus line 36)	and private round cost (0,402,000	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
		JUSTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				1 00
8. 00	Adjusted general inpatient routine service cost per diem (se	e instructions)		1, 442. 21	
8. 00 9. 00		ee instructions) ne 38)		1, 442. 21 83, 648 0	39.

	ATION OF INPATIENT OPERATING COST		Provider C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1	
						Date/Time Prepa 5/26/2023 3:09	
	Cost Center Description	Total I npati ent Cost 1, 00	Total Inpatient Days	e XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4) 5.00	
2.00	NURSERY (title V & XIX only)	243, 679	2.00	3.00 2,256.29	4.00		42.
	Intensive Care Type Inpatient Hospital Units	,]				.,	
4.00 5.00 5.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						43. 44. 45. 46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
	Program inpatient ancillary service cost (Wks					83, 020	
9.00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of PASS THROUGH COST ADJUSTMENTS				column 1)	0 175, 693	
	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D. sum	of Parts I and	15, 807	50.
	Pass through costs applicable to Program inpa					12, 339	
	and IV)	50 and 51				00.414	FA
2.00 3.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud medical education costs (line 49 minus line !	ding capital re	lated, non-ph	ysician anesth	etist, and	28, 146 147, 547	
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>SE J</i>					1
	Program di scharges					0	
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u					0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55.	J ,				0.00	
	Difference between adjusted inpatient operati			line 56 minus	line 53)	0	
	Bonus payment (see instructions)	5	5			0	
. 00	Trended costs (lesser of line 53 \div line 54, oupdated and compounded by the market basket)			0.1	0	0.00	
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year	cost report, u	pdated by the	0.00	60
. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operatin	g costs (line	0	61.
. 00	Relief payment (see instructions)					0	62.
	Allowable Inpatient cost plus incentive payment (see instructions)					0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST	ta thursuit Daas		++!		0	1
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68
	Total title V or XIX swing-bed NF inpatient (PART III - SKILLED NURSING FACILITY, OTHER NU			,		0	69
	Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co	ost per diem (l					71
	Program routine service cost (line 9 x line	,					72
	Medically necessary private room cost applica	5	•	,			73
	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)	•			art II, column		74
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minus		,	1.2			78
	Aggregate charges to beneficiaries for excess				us lino 70)		79
	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost i i mitati O		us IIIE /9)		80
	Inpatient routine service cost per diem rim)				82
	Reasonable inpatient routine service costs (s		· .				83
. 00	Program inpatient ancillary services (see ins	structions)					84
	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	rough 85)				86
	Total observation bed days (see instructions))				1, 480	87

Health Financial Systems PA	RKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1310		Period: From 01/01/2022	Worksheet D-1		
					Date/Time Pre 5/26/2023 3:0	pared: 9 pm	
	Title XIX Hospital		Hospi tal	PPS			
Cost Center Description							
		1.00					
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2, 134, 471	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	1, 169, 677	6, 595, 921	0. 17733	3 2, 134, 471	378, 512	90.00	
91.00 Nursing Program cost	0	6, 595, 921	0.00000	0 2, 134, 471	0	91.00	
92.00 Allied health cost	0	6, 595, 921	0.00000	0 2, 134, 471	0	92.00	
93.00 All other Medical Education	0	6, 595, 921	0.00000	0 2, 134, 471	0	93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1310 Period: From 01/01/2022 To Worksheet D-3 Error Worksheet D-3 Date/Time Prepared: 52/2/2023 30.90 pm Cost Center Description Title XVIII Hospital Cost Cost Inpatient Program Program Program Program Cost Cost Cost Cost Inpatient Program Program Cost	Health Financial Systems PARKVIEW WABASH HOSPITAL,	PARKVI EW WABASH HOSPI TAL, INC.			In Lieu of Form CMS-2552-10		
To 12/31/2022 Date/Time Prepared: 5/26/2023 3:09 pm Cost Center Description Title XVIII Hospital Cost To Charges Inpatient Program Program Program Cost 0:00 00000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30:00 00000 OPERATINE SERVICE COST CENTERS 1.846,147 43.00 ANCILLARY SERVICE COST CENTERS 0.262870 480,184 126,226 50:00 050000 OPERATINE NOM 0.262870 480,184 126,226 51:00 051:00 RECOVERY ROM 0.000000 0 51:00 51:00 52:00 053:00 DELLIVERY ROM & LABOR ROM 1.077377 0 0 52:00 53:00 OS000 PHASTINES OLGCY 0.1335150 342,515 45,674 54:00 60:00 OG000 PHASTINES OLGCY 0.3385174 32,573 45:00 53:00 53:00 OS300 ANESTHESI OLGCY 0.338517126 53:44 54:00 54:00 60:00 OG600 PHASTINES OLGCY 0.338547126 70:34:45 91:033 60:00 71:00 OTOOCUPA	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provide	er CCN: 15-1310		Worksheet D-3			
Title XVIII Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 2) Inpatient Program Cos			From 01/01/2022				
Ittle XVIII Hospital Cost Cost Center Description Ratio of Cost Inpatient Program Charges Inpatient Program (costs (col. 1 x 0:00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30:00 03000 ADULTS & PEDIATRICS 1.846,147 30.00 AND OLIDADO NURSERY ANCILLARY SERVICE COST CENTERS 1.846,147 30.00 50:00 05000 OPERATING ROM 0.262870 480,184 126,226 50.00 50:00 05000 OPERATING ROM 0.00000 0 0 51.00 52:00 05100 RECOVERY ROM 0.00000 0 0 51.00 52:00 05200 DELIVERY ROM 0.00000 0 0 52.00 54:00 05400 RADIOLOGY-DI ARNOSTI C 0.133350 342,515 45,674 54.00 66:00 06600 COLLAPREATORY 0.512271 80.308 41.137 67.00 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<			10 12/31/2022	5/26/2023 3.0	parea: 9 nm		
INPATIENT ROUTINE SERVICE COST CENTERS To Charges Program Costs (col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 1.846,147 30.00 ANCILLARY SERVICE COST CENTERS 1.846,147 30.00 ANCILLARY SERVICE COST CENTERS 5.00 0.262870 480,184 126,226 50.00 50.00 05000 OPERATING ROOM 0.262870 480,184 126,226 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 52.00 05200 DELIVERY ROOM 1.077307 0 0 52.00 53.00 05400 RADIOLOGY-DI ARNOSTI C 0.133350 342,515 45.674 54.00 66.00 066000 SPEECH PATHOLOGY 0.386547 126,703 46.696 66.00 67.00 06700 CCUPATIONAL THERAPY 0.512271 80.308 41.139 677.00 68.00 06800 SPEECH PATHOLOGY 0.438714 32,079 14.074 68.00<	T	tle XVIII	Hospi tal				
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68.00 06800 SPEECH PATHOLOGY 0.438714 32,079 14,074 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 588,729 130,451 69.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.066198 120,649 7,987 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 181,585 44,237 72.00 0.0170.0 DUTPATI ENT SERVICE COST CENTERS 0.205257 873,712 179,336 73.00 0.0200.0 OB800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.00 08802 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 88.01 88.02 0802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09010 EMERGENCY 0.147360 3,117 459 91.00 92.00 09200 DESERVATION BEDS (NON-DI STINCT PART 0.8278				46, 696			
69.00 06900 ELECTROCARDIOLOGY 0.221580 588,729 130,451 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.066198 120,649 7,987 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 181,585 44,237 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 873,712 179,336 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.01 90.01 09010 EMERGENCY 0.147360 3,117 459 91.00 91.00 09100 EMERGENCY 0.827841 19,516 16,156 92.00 92.00 095200 AMBULANCE SERVICES 95.00 00 00500 43,525,249 743,973 200.00 201.00 201.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 5122	271 80, 308	41, 139	67.00		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.066198 120,649 7,987 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 181,585 44,237 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.205257 873,712 179,336 73.00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 0 88.00 88.00 88.00 88.00 88.00 0.000000 0 88.01 88.00 08801 RURAL HEALTH CLINIC 0.000000 0 88.01 88.00 88.00 08802 RURAL HEALTH CLINIC III 0.000000 0 88.01 88.00 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09010 EMERGENCY 0.147360 3,117 459 91.00 91.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART 0.827841 19,516 16,156 92.00 00 09200 DSERVATI ON BEDS (NON-DI STINCT PART 0.827841	68.00 06800 SPEECH PATHOLOGY	0. 4387	14 32, 079	14, 074	68.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 181,585 44,237 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 873,712 179,336 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 88.00 89.00 90.00 90.00 90.00 90.0	69. 00 06900 ELECTROCARDI OLOGY	0. 2215	580 588, 729	130, 451	69.00		
73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 873,712 179,336 73.00 0UTPATIENT SERVICE COST CENTERS 0.00000 0 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09010 EMERGENCY 0.147360 3,117 459 91.00 91.00 09100 EMERGENCY 0.827841 19,516 16,156 92.00 92.00 OSECWATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 95.00 09500 AMBULANCE SERVICES 3,525,249 743,973 200.00 201.00 201.00 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.0661	98 120, 649				
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09010 ENIOR CARE 0.676478 0 90.01 90.01 91.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 0.827841 19,516 16,156 92.00 004000 OHERGENCY 0.827841 19,516 16,156 92.00 01040 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 09500 AMBULANCE SERVICES 95.00 20.00 20.00 20.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 2436	16 181, 585	44, 237	72.00		
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09010 ENIOR CARE 0.676478 0 90.01 91.00 09100 EMERGENCY 0.147360 3,117 459 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 07HER REI MBURSABLE COST CENTERS 0 0 95.00 09500 AMBULANCE SERVICES 95.00 200.00 2,525,249 743,973 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 2	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2052	257 873, 712	179, 336	73.00		
88.01 08801 RURAL HEALTH CLINICII 0.000000 0 88.01 88.02 08802 RURAL HEALTH CLINICIII 0.000000 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09000 SENIOR CARE 0.676478 0 90.01 91.00 09100 EMERGENCY 0.147360 3,117 459 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 07HER REI MBURSABLE COST CENTERS 0 0.827841 19,516 16,156 92.00 200.00 09500 AMBULANCE SERVICES 3,525,249 743,973 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00							
88.02 08802 RURAL HEALTH CLINICIII 0.00000 0 0 88.02 90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09001 SENIOR CARE 0.676478 0 90.01 91.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.147360 3,117 459 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 07HER REI MBURSABLE COST CENTERS 0 0.827841 19,516 16,156 95.00 200.00 09500 AMBULANCE SERVICES 3,525,249 743,973 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00				0			
90.00 09000 CLINIC 0.185241 2,727 505 90.00 90.01 09001 SENIOR CARE 0.676478 0 90.01 91.00 09100 EMERGENCY 0.147360 3,117 459 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 743,973 200.00 201.00 201.00 201.00 201.00 201.00 0 201.00 201.00 0 201.00 0 201.00 2	88.01 08801 RURAL HEALTH CLINIC II	0.0000	000	0	88.01		
90. 01 09001 SENI OR CARE 0.676478 0 90. 01 91. 00 09100 EMERGENCY 0.147360 3, 117 459 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.827841 19, 516 16, 156 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 95. 00 201. 00 201. 00	88.02 08802 RURAL HEALTH CLINIC III	0.0000	000	0	88.02		
91.00 09100 EMERGENCY 0.147360 3,117 459 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.827841 19,516 16,156 92.00 0THER REI MBURSABLE COST CENTERS 0 95.00 09500 AMBULANCE SERVICES 95.00 95.00 200.00 201.00 3,525,249 743,973 200.00 201.00	90. 00 09000 CLINIC	0. 1852	241 2, 727	505	90.00		
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.827841 19, 516 16, 156 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 3, 525, 249 743, 973 200. 00 201. 00 201. 00 0 201. 00 0 201. 00 201. 00 201. 00 0 201. 00 0 201. 00 201	90. 01 09001 SENI OR CARE	0. 6764	78 0	0	90.01		
OTHER REI MBURSABLE COST CENTERS95. 0009500AMBULANCE SERVICES200. 00Total (sum of lines 50 through 94 and 96 through 98)3, 525, 249201. 00Less PBP Clinic Laboratory Services-Program only charges (line 61)0	91.00 09100 EMERGENCY	0. 1473	360 3, 117	459	91.00		
95. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 3, 525, 249 743, 973 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00		0. 8278	341 19, 516	16 <u>,</u> 156	92.00		
200.00 Total (sum of lines 50 through 94 and 96 through 98) 3,525,249 743,973 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	OTHER REIMBURSABLE COST CENTERS						
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95. 00 09500 AMBULANCE SERVICES				95.00		
			3, 525, 249	743, 973	200.00		
	201.00 Less PBP Clinic Laboratory Services-Program only charges (line	51)	0		201.00		
	202.00 Net charges (line 200 minus line 201)		3, 525, 249		202.00		

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 01/01/2022		
	Component	CCN: 15-Z310	To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
	Title	XVIII	wing Beds - SNF		^y piii
Cost Center Description		Ratio of Cost		Inpatient	
		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS			-	-	
50.00 O5000 OPERATING ROOM		0. 26287		0	
51.00 05100 RECOVERY ROOM		0.00000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		1.07730		0	
53.00 05300 ANESTHESI OLOGY		0.00000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 13335		41	
60. 00 06000 LABORATORY		0. 13517		943	
66.00 06600 PHYSI CAL THERAPY		0. 36854		4, 920	
67.00 06700 OCCUPATI ONAL THERAPY		0. 51227			
68.00 06800 SPEECH PATHOLOGY		0. 43871		966	
69. 00 06900 ELECTROCARDI OLOGY	_	0. 22158			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	l	0.06619		226	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 24361		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 20525	7 3, 191	655	73.00
OUTPATIENT SERVICE COST CENTERS		0.00000			
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	
90. 00 09000 CLINIC		0. 18524		0	
90. 01 09001 SENI OR CARE		0.67647		0	
91.00 09100 EMERGENCY	-	0.14736		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR OTHER REIMBURSABLE COST CENTERS	1	0. 82784	1 0	0	92.00
					05 00
95.00 09500 AMBULANCE SERVICES	and 04 through 08)		11 210	14 454	95.00
200.00 Total (sum of lines 50 through 94 a 201.00 Less PBP Clinic Laboratory Services			44, 310	14, 656	
201.00Less PBP Clinic Laboratory Services202.00Net charges (line 200 minus line 20			44, 310		201.00 202.00
202.00 piver charges (The 200 minus the 20	(1)	I	44, 310	l	202.00

INPATIENT ANCIELLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1310 Period: From 01/01/2022 To Worksheet D-3 Date/Time Prepared: 52/2/2023 30.90 pmt Cost Center Description Ratio of Cost To Charges Hospital PPS (col. 1 x) col. 2) Inpatient Program Costs (col. 2) Inpatient Program Costs (col. 2) Inpatient Program Costs (col. 1 x) col. 2) Inpatient Program Costs (col. 1 x) col. 2) Inpatient Program Costs (col. 1 x) col. 2) 3.00 0.00 03000 ADULTS & PEDIATRICS 114,875 30.00 0.00 03000 ADULTS & PEDIATRICS 7,204 43.00 0.00 03000 ADULTS & NERVICE COST CENTERS 0.262870 36,236 9,525 50:00 00 0.000000 0 0 51.00 51:00 05000 ADULTS WICE COST CENTERS 0.1077307 414 446 52.00 50:00 000000 ADUSTHESTOLOGY 0.36323 8.071 54.00 54.00 50:00 05000 ADURSTHESTOLOGY 0.133350 60.523 8.071 54.00 60:00 060000 CONCORTATING READY 0.133350 60.523 8.071 54.00 60:00 <td< th=""><th>Health Financial Systems PARKVIEW WABASH HOSPITAL, IN</th><th>C.</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></td<>	Health Financial Systems PARKVIEW WABASH HOSPITAL, IN	C.	In Lie	u of Form CMS-	2552-10
Image: Total State State Total State State State Total State State State State Total State	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider	CCN: 15-1310			
Title XIX Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program			From 01/01/2022		
Title XIX Hospital PPS Cost Center Description Ratio of Cost Inpatient Program Costs (col. 1 x Program (charges Program (charge Progra			10 12/31/2022		epared:
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 114,875 30.00 43.00 043000 NURSERY 7,204 43.00 AMOLILARY SERVICE COST CENTERS 7,204 43.00 50.00 05000 OPERATING ROOM 0.262870 36,236 9,525 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 53.00 50.00 05400 RADICST KROM 0.107307 414 446 52.00 51.00 05400 RADICGY ROOM 0.000000 0 0 53.00 50.00 05400 RADICGY DI AGNOSTIC 0.133350 60,523 8.071 54.00 60.00 06600 PHYSICAL HERAPY 0.313179 116,201 15.708 66.00 60.00 06900 SPECH PHOLOGY 0.438714 2.364 1.037 68.00 68.00 68.00 68.00 68.00 67.00 77.00	Ti	tle XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 0 03000 ADULTS & PEDIATRICS 30.00 3.00 3.00 43.00 04300 NURSERY 7,204 43.00 ANCILLARY SERVICE COST CENTERS 7,204 43.00 50.00 05000 OPERATING ROOM 0.262870 36,236 9,525 50.00 51.00 05000 OPERATING ROOM 0.262870 36,236 9,525 50.00 52.00 05200 DELIVERY ROOM 0.000000 0 0 51.00 52.00 05200 DELIVERY ROM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOCY 0.135179 116,201 15,708 60.00 64.00 06000 LABORATORY 0.368547 4,820 1,776 66.00 65.00 06200 OPECCHRATIONAL THERAPY 0.568547 4,820 1,776 66.00 60.00 06000 ELECTROCARDI OLOGY 0.438714 2,364 1,037 68.00 69.00 67.00 67.00 67.00 67.00				Inpatient	
INPATI ENT ROUTI NE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 114,875 3.00 31.00 04300 AUULTS & PEDIATRICS 114,875 30.00 ANCILLARY SERVICE COST CENTERS 7,204 43.00 50.00 50500 RECOVERY ROOM 0.262870 36,236 9,525 50.00 50500 DELIVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 51.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 (ABUI CGV-ENY ROOM & LABOR ROOM 1.077307 414 446 52.00 50.00 05300 ANESTHESI OLOGY 0.133350 60,523 8,071 54.00 60.00 06600 PHYSI CAL THERAPY 0.38547 4,820 1,776 66.00 60.00 06600 DELECTROCARDI OLOGY 0.221580 47,973 10,630 69.00 69.00 06900 ELECTROCARDI OLOGY 0.238547 4,830 10.77 64.00 70.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0.243616		To Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 43.00 04300 NURSERY 7,204 43.00 ANCILLARY SERVICE COST CENTERS 0.262870 36,236 9,525 50.00 50.00 05200 PERATING ROOM 0.262870 36,236 9,525 50.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 64.00 OAGO RAD OLOGY-DI AGNOSTI C 0.133159 116,201 15,708 60.00 60.00 06600 PHYSI CAL THERAPY 0.38174 2.364 1,037 64.00 60.00 06600 DELCT CARDI DLOGY 0.438714 2.364 1,037 68.00 61.00 06700 DELICACARDI DLOGY 0.221580 47,973 10,630 69.00 62.00 06600 DELECT ROARDI DLOGY 0.221580 47,973 10,630 69.00 63.00 06800 DELECH ACHARDE TO PATIENT 0.266198 6,302 477			Charges	(col. 1 x	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 03000 RULTS & PEDI ATRI CS 114, 875 30.00 43.00 04300 NURSERY 7, 204 30.00 ANCI LLARY SERVI CE COST CENTERS 7, 204 43.00 50.00 05000 OPERATI NG ROOM 0.262870 36, 236 9, 525 50.00 52.00 05200 DEL IVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOGY 0.0000000 0 0.53.00 54.00 05400 RADI OLGGY-JI AGNOSTI C 0.133350 60, 523 8,071 54.00 60.00 06600 PHYSI CAL THERAPY 0.368547 4,820 1,776 66.00 61.00 06600 PHYSI CAL THERAPY 0.3438714 2.364 1,037 68.00 62.00 06600 SPEECH PATHOLOGY 0.438714 2.364 1,037 68.00 69.00 06900 ELECTROCARDI DLOGY 0.221580 47,973 10,630 69.00 71.00 07100 IMELI CAL SUPPLIES CHARGED TO PATI ENTS 0.243616 0 0 72.00 73.00 07300 DRUSS CHARGED TO PATI ENTS 0.243616 0 0 73.00			-		
30.00 03000 ADULTS & PEDIATRICS 114,875 30.00 43.00 04300 NURSERY 7,204 43.00 ANDULLARY SERVICE COST CENTERS 7,204 43.00 50.00 05000 OPERATING ROOM 0.262870 36,236 9,525 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTI C 0.135179 116,201 15,708 60.00 60.00 066000 LABORATORY 0.135179 116,201 15,708 60.00 65.00 06500 SPEECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.438714 2,364 1,037 68.00 69.00 07200 DRUES CHARGED TO PATIENT 0.262877 72,120 14,803 73.00 71.00 000 DRUE CALSUPPLIES CHARGED TO PATIENT 0.265277 72,120 14,803 73.00		1.00	2.00	3.00	
43. 00 04300 NURSERY 7, 204 43. 00 ANCI LLARY SERVICE COST CENTERS 0.00000 0 50.00 5000 00 5000 00 5000 00 0.00000 0 0 51.00 51.00 51.00 51.00 5000 00 0.00000 0 0 51.00 51.00 51.00 52.00 05300 ALEVERY ROM & LABOR ROM 0.000000 0 0 53.00 05300 ANESTHESI OLOGY 0.133350 60, 523 8,071 54.00 66.00 0.00000 0.0000 0 0 53.00 0.368547 4,820 1,776 66.00 60.00 06000 DABORATORY 0.348714 2,364 1,037 68.00 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 1,776 66.00 69.00 1,333 67.00 68.00 0 1,33 67.00 69.00 1,778 1,433 67.00 69.00 1,700 1,433 67.00 69.00 1,010 1,433					
ANCL LLARY SERVICE COST CENTERS 50. 00 05000 DPERATING ROOM 0.262870 36,236 9,525 50. 00 51. 00 05100 RECOVERY ROOM 0.000000 0 0 51. 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.077307 414 446 52. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 53. 00 60. 00 06400 RADI OLOGY-DI AGNOSTI C 0.133150 60. 523 8. 071 54. 00 60. 00 06000 PHYSI CAL THERAPY 0.135179 116, 201 15, 708 66. 00 61.00 06700 OCCUPATI ONAL THERAPY 0.512271 2, 798 1.433 67. 00 62.00 06600 PHYSI CAL THERAPY 0.512271 2, 798 1.433 67. 00 69.00 06500 SPEECH PATHOLOGY 0.438714 2. 364 1.037 68. 00 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 205257 72, 120 14, 803 73. 00 73.00 07300 DPUGS CHARGED TO PATIENTS 0. 205257 72, 120 14, 803 <td></td> <td></td> <td>114, 875</td> <td></td> <td></td>			114, 875		
50.00 OSO00 OPERATING ROOM 0.262870 36,236 9,525 50.00 51.00 OS100 RECOVERY ROOM & LABOR ROOM 0.000000 0 0 51.00 52.00 DELLVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 05.00 DELVERY ROOM & LABOR ROOM 0.000000 0 0 53.00 54.00 OS400 RADIOLOGY-DI AGNOSTI C 0.133350 60,523 8,071 54.00 06.00 LABORATORY 0.133350 60,523 8,071 54.00 0.6000 LABORATORY 0.368547 4,820 1,776 66.00 0.00 0.00000 0 0.770 14.433 67.00 0.6100 AGROSTORY 0.368547 4,820 1,776 66.00 0.00 0.00000 0 0.368547 4,820 1,776 66.00 0.00 0.00000 0 0.221580 47,973 10,630 69.00 0 0.2000 10.00000 0 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.20.00 72.00 0.20.00 0.00000 0 0.00000 0			7, 204		43.00
51.00 65100 RECOVERY ROOM 0.000000 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 63.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.133350 60.523 8.071 54.00 60.00 ABORATORY 0.385877 4.820 1.776 66.00 60.00 CCUPATI ONAL THERAPY 0.385877 4.820 1.776 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.512271 2.798 1.433 67.00 68.00 OSEECH PATHOLOGY 0.438714 2.364 1.037 68.00 69.00 0.0221580 47,973 10.630 69.00 69.00 0 72.00 73.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.243616 0 0 72.00 73.00 72.100 14.803 73.00 73.00 0.000000 0 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00 88.00					
52.00 05200 DELLIVERY ROOM & LABOR ROOM 1.077307 414 446 52.00 53.00 05300 ANESTHESI OLOGY 0.00000 0 0.53.00 64.00 05400 RADI LOGY-DI AGNOSTI C 0.133350 60.523 8.071 54.00 66.00 06000 LABORATORY 0.135179 116.201 15,708 60.00 67.00 06CUPATI ONAL THERAPY 0.368547 4,820 1,776 66.00 67.00 06CUPATI ONAL THERAPY 0.512271 2,798 1,433 67.00 68.00 06800 SPECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.243616 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.243616 0 0 73.00 00300 RURAL HEALTH CLINIC II 1.347862 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC III 1.347862 0 0 88.00 90.00 O9000 LINIC 0 0.85241 456 84		0. 2628	70 36, 236	9, 525	50.00
53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.133350 60,523 8,071 54.00 60.00 LABORATORY 0.135179 116,201 15,708 60.00 64.00 06600 PHYSI CAL THERAPY 0.368547 4,820 1,776 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.512271 2,798 1,433 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 47,973 10,630 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.205257 72.120 14,803 70.00 73.00 O3000 DRUGS CHARGED TO PATIENTS 0.200000 0 88.01 88.00 88.00 08800 RURAL HEALTH CLINIC II 1.107504 0 0 88.02 90.00 O9000				0	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.133350 60, 523 8, 071 54.00 60.00 06000 LABORATORY 0.135179 116, 201 15, 708 60.00 66.00 06000 PHYSI CAL THERAPY 0.368547 4, 820 1, 776 66.00 67.00 0CCUPATI ONAL THERAPY 0.512271 2, 798 1, 433 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 2, 364 1, 037 68.00 69.00 OEJOCUPATI ONAL THERAPY 0.221580 47, 973 10, 630 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.066198 6, 302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 0 0 72.00 73.00 OR300 RURAL HEALTH CLINIC 1.347862 0 88.01 88.01 88.01 08802 RURAL HEALTH CLINIC 111 1.107504 0 88.02 88.02 90.01 O9000 CLINIC 0.827841 5.011 41.92.91.00 91.00 D9100 <t< td=""><td></td><td></td><td></td><td>446</td><td></td></t<>				446	
60.00 06000 LABORATORY 0.135179 116, 201 15, 708 60.00 66.00 06600 PHYSI CAL THERAPY 0.368547 4, 820 1, 776 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.512271 2, 798 1, 433 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 2, 364 1, 037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 47, 973 10, 630 69.00 71.00 MTIO MEDI CAL SUPPLIES CHARGED TO PATIENT 0.066198 6, 302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 0 72.00 017200 DRUGS CHARGED TO PATIENTS 0.205257 72, 120 14, 803 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.01 08801 RURAL HEALTH CLINIC III 1.107504 0 88.00 88.01 08802 RURAL HEALTH CLINIC III 1.107504 0 0 88.02 90.01 90.00 O9000 CLINIC 0.143560 0	53. 00 05300 ANESTHESI OLOGY	0.0000	00 0	0	53.00
66.00 06600 PHYSI CAL THERAPY 0.368547 4,820 1,776 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.512271 2,798 1,433 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 47,973 10,630 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 72.00 73.00 07300 DRGS CHARGED TO PATIENTS 0.205257 72,120 14,803 73.00 0017DATIENT SERVICE COST CENTERS 1.347862 0 88.00 88.01 88.01 88.01 88.02 88.01 88.02 88.01 88.02 90.00 90.01 88.02 90.01 88.02 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1333	50 60, 523	8, 071	54.00
67.00 06700 0CCUPATIONAL THERAPY 0.512271 2,798 1,433 67.00 68.00 06800 SPEECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDIOLOGY 0.21580 47,973 10,630 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 72,120 14,803 73.00 010TPATIENT SERVICE COST CENTERS 0 0.08800 RURAL HEALTH CLINIC II 1.347862 0 0 88.00 88.00 08802 RURAL HEALTH CLINIC III 1.347862 0 0 88.02 90.01 09001 SENIOR CARE 0.185241 456 84 90.00 90.01 09100 EMERGENCY 0.147360 0 90.01 90.01 91.00 09100 SENVATION BEDS (NON-DISTINCT PART 0.827841 5.011 4.148 92.00					
68.00 06800 SPEECH PATHOLOGY 0.438714 2,364 1,037 68.00 69.00 06900 ELECTROCARDI OLOGY 0.221580 47,973 10,630 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.243616 0 0 72.00 0.0100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.205257 72,120 14,803 73.00 0.017300 PURGS CHARGED TO PATI ENTS 0.000000 0 88.00 0.800 RURAL HEALTH CLINIC 1.347862 0 88.00 88.00 08802 RURAL HEALTH CLINIC III 1.107504 0 88.02 90.00 09000 CLINIC 0.8102 0.8202 90.00 90.01 09000 SENIOR CARE 0 0 98.02 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 092000 DESERVATION BEDS (NON-DI STINCT PART 0.827841 5,011				1, 776	66.00
69.00 06900 ELECTROCARDIOLOGY 0.221580 47,973 10,630 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.243616 0 0 72.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC 1 347862 0 0 88.01 88.01 08801 RURAL HEALTH CLINIC III 1 1.107504 0 0 88.02 90.00 09000 CLINIC 0 0.8807 0 0 90.01 91.00 090100 EMERGENCY 0.185241 456 84 90.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART 0.827841 5.011 4.148 92.00 92.00 09200 MBULANCE SERVICES 95.00 95.00 95.00 200.00 <	67.00 06700 OCCUPATI ONAL THERAPY	0. 5122	71 2, 798	1, 433	67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.066198 6,302 417 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 72.120 14,803 73.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 1 347862 0 0 88.01 88.01 08801 RURAL HEALTH CLINIC II 1 1.347862 0 0 88.01 88.02 08000 CLINIC 0.185241 456 84 90.00 90.00 09000 CLINIC 0.147360 101,397 14,942 91.00 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0.827841 5,011 4,148 92.00 07HER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 09500 AMBULANCE SERVI	68.00 06800 SPEECH PATHOLOGY	0. 4387	14 2, 364	1, 037	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243616 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 72,120 14,803 73.00 0UTPATIENT SERVICE COST CENTERS 0.00000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 1 347862 0 0 88.01 88.01 08802 RURAL HEALTH CLINIC II 1.107504 0 0 88.01 88.02 0800 CLINIC 0.0802 RURAL HEALTH CLINIC III 0 88.01 90.00 09000 CLINIC 0 0 88.01 90.01 09001 SENIOR CARE 0.676478 0 90.01 90.01 09100 EMERGENCY 0.147360 101.397 14,942 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 20500 AS8,020 200.00 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	0. 2215	80 47, 973	10, 630	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.205257 72,120 14,803 73.00 0UTPATIENT SERVICE COST CENTERS 000000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.01 08801 RURAL HEALTH CLINIC II 1.347862 0 0 88.02 09.00 09000 CLINIC 1.107504 0 0 88.02 90.00 09000 CLINIC 0.676478 0 0 90.01 90.01 09100 EMERGENCY 0.147360 101,397 14,942 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 95.00 200.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.0661	98 6, 302	417	71.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 1.347862 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC II 1.347862 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 1.107504 0 0 88.02 90.00 09000 CLINIC 0.185241 456 84 90.00 90.01 09010 SENIOR CARE 0 0 90.01 90.01 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 095ERVATI ON BEDS (NON-DI STINCT PART 0.827841 5,011 4,148 92.00 0THER REI MBURSABLE COST CENTERS 0 0.827841 5,011 4,148 92.00 95.00 09500 AMBULANCE SERVICES 95.00 95.00 200.00 200.00 200.00 200.00 201.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 2436	16 0	0	72.00
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 1.347862 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC II 1.107504 0 0 88.02 90.00 09000 CLINIC 0.185241 456 84 90.00 90.01 09001 SENIOR CARE 0.676478 0 0 90.01 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 095ERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 07HER REI MBURSABLE COST CENTERS 0 0.827841 5,011 4,148 92.00 95.00 09500 AMBULANCE SERVICES 95.00 09500 AMBULANCE SERVICES 95.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2052	57 72, 120	14, 803	73.00
88.01 08801 RURAL HEALTH CLINIC II 1.347862 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 1.107504 0 88.02 90.00 09000 CLINIC 0.185241 456 84 90.00 90.01 09001 SENIOR CARE 0.676478 0 0 90.01 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 95.00 09500 AMBULANCE SERVICES 70.41 (sum of lines 50 through 94 and 96 through 98) 456,615 83,020 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00					
88.02 08802 RURAL HEALTH CLINICIII 1.107504 0 88.02 90.00 09000 CLINIC 0.185241 456 84 90.00 90.01 09001 SENIOR CARE 0.676478 0 0 90.01 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 0THER RIMBURSABLE COST CENTERS 0 0.827841 5,011 4,148 92.00 200.00 O9500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00 95.00 200.00 201.00				0	
90.00 09000 CLINIC 0.185241 456 84 90.00 90.01 09001 SENIOR CARE 0.676478 0 90.01 91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 0THER REIMBURSABLE COST CENTERS 0 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 456,615 83,020 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00				0	
90. 01 09001 SENI OR CARE 0 0 90. 01 91. 00 09100 EMERGENCY 0. 147360 101, 397 14, 942 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 827841 5, 011 4, 148 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 205. 00 Total (sum of lines 50 through 94 and 96 through 98) 456, 615 83, 020 200. 00 201. 00		1. 1075	04 0	0	
91.00 09100 EMERGENCY 0.147360 101,397 14,942 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 0THER REIMBURSABLE COST CENTERS 0 95.00 95.00 95.00 456,615 83,020 200.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00		0. 1852	41 456	84	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.827841 5,011 4,148 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 456,615 83,020 200.00 201.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00		0. 6764		-	
OTHER REI MBURSABLE COST CENTERS95. 0009500AMBULANCE SERVI CES95. 00200. 00Total (sum of Lines 50 through 94 and 96 through 98)456, 61583, 020201. 00Less PBP Clinic Laboratory Services-Program only charges (Line 61)0201. 00				14, 942	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 456, 615 83, 020 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00		0. 8278	41 5, 011	4, 148	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 456,615 83,020 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95.00 09500 AMBULANCE SERVICES				95.00
			456, 615	83, 020	
202.00 Net charges (line 200 minus line 201) 456,615 202.00)	0		•
	202.00 Net charges (line 200 minus line 201)		456, 615		202.00

ALCUL	Financial Systems PARKVIEW WABASH HOSPI ATION OF REIMBURSEMENT SETTLEMENT Pr	rovider CCN: 15-1310	Period:	u of Form CMS-2 Worksheet E	2002-1
			From 01/01/2022 To 12/31/2022	Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/26/2023 3:0 Cost	9 pm
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			7, 756, 399	
2.00 8.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		0	
. 00	Outlier payment (see instructions)			0	4.0
. 01 . 00	Outlier reconciliation amount (see instructions)	ons)		0 0. 000	
5.00 5.00	Enter the hospital specific payment to cost ratio (see instructi Line 2 times line 5	UIIS)		0.000	
. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
3.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV,	col 13 line 200		0	
0.00	Organ acquisitions	cor: 10, 1110 200		0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 756, 399	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
2.00	Ancillary service charges			0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	e 69)		0	
4.00	Customary charges			0	14.0
	Aggregate amount actually collected from patients liable for pay			0	
6.00	Amounts that would have been realized from patients liable for p had such payment been made in accordance with 42 CFR §413.13(e)	payment for services	on a chargebasis	0	16.0
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.0
8.00	Total customary charges (see instructions)			0	
9.00	Excess of customary charges over reasonable cost (complete only instructions)	IT TINE 18 exceeds T	ine II) (see	0	19.0
0. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds I	ine 18) (see	0	20.0
1. 00	instructions) Lesser of cost or charges (see instructions)			7, 833, 963	21 0
2.00	Interns and residents (see instructions)			7,033,703 0	
3.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	
.4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.0
5.00	Deductibles and coinsurance amounts (for CAH, see instructions)			77, 192	25.00
6.00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtatal [((inser 21 and 24 minus the sum of lines 25 and 2() all			6, 880, 586	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	is the sum of times 2		876, 185	27.0
8.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 876, 185	
1.00	Primary payer payments			391	
2.00	Subtotal (line 30 minus line 31)	``		875, 794	32.0
3. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. 1-5, line 11)))		0	33.0
4.00	Allowable bad debts (see instructions)			815, 690	34.0
5.00	Adjusted reimbursable bad debts (see instructions)	ati ana)		530, 199 621, 274	
6.00 7.00	Allowable bad debts for dual eligible beneficiaries (see instruc Subtotal (see instructions)	strons)		1, 405, 993	
	MSP-LCC reconciliation amount from PS&R			0	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50 9.75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39.5 39.7
9.97	Demonstration payment adjustment amount before sequestration			0	
9.98	Partial or full credits received from manufacturers for replaced	d devices (see instru	ctions)	0	
9. 99 0. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 405, 993	
0.01	Sequestration adjustment (see instructions)			17, 716	
	Demonstration payment adjustment amount after sequestration			0	
0.03	Sequestration adjustment-PARHM or CHART pass-throughs			2, 248, 170	40.0
1.00	Interim payments Interim payments-PARHM or CHART			2, 240, 170	41.0
2.00	Tentative settlement (for contractors use only)			0	
2.01	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			-859, 893	42.0 43.0
3.00	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-004, 843	43.0
4.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				-
0. 00	Original outlier amount (see instructions)			0	90.00
1.00	Outlier reconciliation adjustment amount (see instructions)			0	91.0
2.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			-	94.0

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	Period: From 01/01/2022	Worksheet E	
		To 12/31/2022	Date/Time Pre	pared:
			5/26/2023 3:0	9 pm
	Title XVIII	Hospi tal	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F		Worksheet E-1 Part I Date/Time Prep 5/26/2023 3:00	pared:
			XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Par	LB	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	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		1, 447, 853 0		2, 248, 170 0	1.00 2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3. 02			0		0	3.02
3.03			0		0	3.03
3.04 3.05			0		0	3.04 3.05
3.05	Provider to Program		0		0	3.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.5
3.52			0		0	3.52
3.53 3.54			0		0	3.53 3.54
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3.54
5. 77	3. 50-3. 98)		0		0	5. 7
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		1, 447, 853		2, 248, 170	4.00
	TO BE COMPLETED BY CONTRACTOR			I		
i. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.0
- 01	Program to Provider					- A
5. 01 5. 02	TENTATI VE TO PROVI DER		0		0	5.0 [°] 5.0
5.02			0		0	5.0
	Provider to Program			1		
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51 5. 52			0		0	5.5 5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5.9
, ,	5. 50-5. 98)		0		Ű	0.7
b. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5.01	SETTLEMENT TO PROVIDER		327, 120		0	6.0
0.02	SETTLEMENT TO PROGRAM		1 774 072		859, 893	6.0
. 00	Total Medicare program liability (see instructions)		1, 774, 973	Contractor	1,388,277 NPR Date	7.0
				Number	(Mo/Day/Yr)	
		(1.00	2.00	

IALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022		
					5/26/2023 3:0	9 pm
				<u>Swing Beds - SN</u>		
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3, 00	4,00	
00	Total interim payments paid to provider	1.00	50, 93		4.00	1.0
00	Interim payments payable on individual bills, either		00, 70	0	0	
	submitted or to be submitted to the contractor for				-	
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52 53				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
//	3, 50-3, 98)			0	0	J 3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		50, 93	35	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	15
02				0	0	5
03				0	0	5
	Provider to Program			- 1	1	
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		
77	5. 50-5. 98)			0	0	5
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					.
D1	SETTLEMENT TO PROVIDER		8, 26	8	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		59, 20		0	7
				Contractor	NPR Date	
)	Number	(Mo/Day/Yr)	
		Ĺ)	1.00	2.00	8

Heal th	Financial Systems PARKVIEW WABASH HO	SPITAL, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1310	Period: From 01/01/2022	Worksheet E-	1
			To 12/31/2022		
		Title XVIII	Hospi tal	Cost	<u> 14 hiii</u>
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
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				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of α line 168	certified HIT 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	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
I	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 I	line 31) (see instructio	ns)		32.00

	Financial Systems PARKVIEW WABASH HOSPITA TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1310	Peri od:	u of Form CMS-2 Worksheet E-2	
	Com	ponent CCN: 15-Z310	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		45, 156	0	1.0
	npatient routine services - swing bed-NF (see instructions)			-	2.0
6.00 A	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,			0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b nstructions)	ed pass-through, see	e		
	Nursing and allied health payment-PARHM or CHART (see instruction:	5)			3.0
	Per diem cost for interns and residents not in approved teaching	,		0.00	4.0
	nstructions)			_	
	Program days	uati ana)	31	0	5.0
	nterns and residents not in approved teaching program (see instru- Jtilization review - physician compensation - SNF optional method		0	0	6.0 7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	oni y	59, 959	0	8.0
	Primary payer payments (see instructions)		0	0	9.0
	Subtotal (line 8 minus line 9)		59, 959	0	10.0
	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11.0
	professional services)		50.050	0	10 0
	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records) (e	valuda col neuronea	59, 959 0	0	12. C
	for physician professional services)		0	0	13.0
	30% of Part B costs (line 12 x 80%)			0	14.0
	Subtotal (see instructions)		59, 959	0	15.0
6.00 0	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
	Pioneer ACO demonstration payment adjustment (see instructions)				16.5
	Rural community hospital demonstration project (§410A Demonstration	on) payment	0		16.
	adjustment (see instructions)		0	0	16.
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)	0	0	
9.00 1	Fotal (see instructions)		59, 959	0	19.0
	Sequestration adjustment (see instructions)		756	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM or CHART pass-throughs			0	19.
	Sequestration for non-claims based amounts (see instructions) nterim payments		50, 935	0	19.1 20.0
1	nterim payments-PARHM or CHART		50, 755	0	20.0
1	Fentative settlement (for contractor use only)		0	0	21.0
	Fentative settlement-PARHM or CHART (for contractor use only)				21.
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19	9.25, 20, and 21)	8, 268	0	
	Balance due provider/program-PARHM or CHART (see instructions)				22.0
	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub. 15-2,	0	0	23.
	chapter 1, §115.2 Aural Community Hospital Demonstration Project (§410A Demonstratio	on) Adjustment			-
	s this the first year of the current 5-year demonstration period				200.
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				0.01
	Medicare swing-bed SNF inpatient routine service costs (from Wkst. 56 (title XVIII hospital))	. D-I, Pt. II, IIne			201. (
	Medicare swing-bed SNF inpatient ancillary service costs (from Wk:	st D-3 col 3 liu	he		202.0
	200 (title XVIII swing-bed SNF))				
03. 00 1	Fotal (sum of lines 201 and 202)				203.
	Medicare swing-bed SNF discharges (see instructions)				204.
	computation of Demonstration Target Amount Limitation (N/A in firsteriod)	st year of the curre	ent 5-year demons	tration	
	Medicare swing-bed SNF target amount				205.
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206.0
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen				
07. 00 F	Program reimbursement under the §410A Demonstration (see instruct	i ons)			207.0
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	ol. 1, sum of lines	1		208. (
1	and 3) Nelivetment to Medicara awing had SNE DDS novments (and instruction				200
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction Reserved for future use	15)			209. (210. (
	comparision of PPS versus Cost Reimbursement				_∠ 10. (
	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 209)	plus line 210) (see			215. (

	Financial Systems PARKVIEW WABASH ATION OF REIMBURSEMENT SETTLEMENT PARKVIEW WABASH	HOSPITAL, INC.	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1310	From 01/01/2022	Part V	5
			To 12/31/2022		epar
				5/26/2023 3:0	
		Title XVIII	Hospi tal	Cost	
				1.00	-
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	T REIMBURSEMENT		
00	Inpatient services			2, 080, 902	
00	Nursing and Allied Health Managed Care payment (see instru	ctions)		0	
00	Organ acquisition			0	
01	Cellular therapy acquisition cost (see instructions)			0	
00 00	Subtotal (sum of lines 1 through 3.01)			2, 080, 902 0	
00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instructions	<u>١</u>		2, 101, 711	
00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 101, 711	
	Reasonable charges				
00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	10
	Customary charges				
. 00	Aggregate amount actually collected from patients liable f	or payment for services on	a charge basis	0	11
. 00	Amounts that would have been realized from patients liable		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.1	3(e)			
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
. 00	3 3 1	anly if line 14 exceeded	100 () (000	0	
. 00	Excess of customary charges over reasonable cost (complete instructions)	only if line 14 exceeds i	The 6) (See	0	15
5. 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 b exceeds in	110 14) (300	0	
. 00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			2, 101, 711	
	Deductibles (exclude professional component)			315, 724	
	Excess reasonable cost (from line 16)			1 705 007	
	Subtotal (line 19 minus line 20 and 21)			1, 785, 987 5, 057	
	Coinsurance Subtotal (line 22 minus line 23)			1, 780, 930	
	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		25, 681	
	Adjusted reimbursable bad debts (see instructions)			16, 693	
	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		11, 792	
	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · ·		1, 797, 623	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruct	i ons)		0	29
	Recovery of accelerated depreciation.			0	29
	Demonstration payment adjustment amount before sequestration	on		0	1
	Subtotal (see instructions)			1, 797, 623	
. 01	Sequestration adjustment (see instructions)			22, 650	
. 02	Demonstration payment adjustment amount after sequestratio	n		0	
. 03	Sequestration adjustment-PARHM or CHART			1 447 050	30
. 00	Interim payments			1, 447, 853	
	Interim payments-PARHM or CHART			~	31
2.00 2.01	Tentative settlement (for contractor use only) Tentative settlement-PARHM or CHART (for contractor use on	120		0	32
	Balance due provider/program (line 30 minus lines 30.01, 3)	5.		327, 120	
נוני) א			03 31 01 and	327, 120	33
3.00 3.01	IBALANCE QUE DROVIDER/DRODRAM-PARHM OR CHART (TIMES 2 3 1				
s. 00 s. 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 1 32.01)	o, and zo, minus rifles so.	05, 51.01, and		

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column		Fr	eriod: fom 01/01/2022 o 12/31/2022	Worksheet G Date/Time Pre 5/26/2023 3:0	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	1, 350	0	0	0	1.00
. 00	Temporary investments	0	0	0	0	2.00
. 00	Notes receivable	0	0	0	0	3.00
. 00 . 00	Accounts recei vabl e Other recei vabl e	23, 859, 020 709	0	0	0	4.00
. 00	Allowances for uncollectible notes and accounts receivable	-14, 709, 521	0	0	0	6.00
. 00	Inventory	1, 034, 532	0	0	0	7.00
. 00	Prepai d expenses	21, 726	0	0	0	8.00
. 00	Other current assets	0	0	0	0	9.00
	Due from other funds Total current assets (sum of lines 1-10)	-22, 201, 486 -11, 993, 670	0	0	0	10.00
1.00	FIXED ASSETS	11, 773, 070		0		1 11.00
2.00	Land	1, 208, 757	0	0	0	12.00
	Land improvements	1, 875, 057	0	0	0	13.00
	Accumulated depreciation	-931, 449	0	0	0	14.00 15.00
	Buildings Accumulated depreciation	31, 518, 742 -7, 122, 819	0	0	0	16.0
	Leasehold improvements	0	0	0	0	17.0
	Accumulated depreciation	0	0	0	0	18.0
	Fixed equipment	2, 180, 492	0	0	0	19.0
	Accumulated depreciation Automobiles and trucks	-698, 476 18, 500	0	0	0	20.0 21.0
	Accumulated depreciation	-18, 500	0	0	0	21.0
	Major movable equipment	14, 000, 454	0	0	0	23.0
	Accumulated depreciation	-9, 239, 516	0	0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets Accumulated depreciation	0	0	0	0	27.0 28.0
	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.0
	Total fixed assets (sum of lines 12-29)	32, 791, 242	0	0	0	30.00
1 00	OTHER ASSETS	0				
	Investments Deposits on Leases	0	0	0	0	31.0
	Due from owners/officers	0	0	0	0	33.0
	Other assets	0	0	0	0	34.0
	Total other assets (sum of lines 31-34)	0	0	0	0	35.0
6.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	20, 797, 572	0	0	0	36.0
7 00	Accounts payable	1, 538, 725	0	0	0	37.0
	Salaries, wages, and fees payable	636, 352	0	0	0	38.00
9.00	Payroll taxes payable	0	0	0	0	39.0
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	41.0 42.0
	Accelerated payments Due to other funds	0	0	0	0	
	Other current liabilities	7, 301, 222	-	0	0	44.0
5.00	Total current liabilities (sum of lines 37 thru 44)	9, 476, 299	0	0	0	45.0
	LONG TERM LIABILITIES					1
	Mortgage payable Notes payable	0	0	0	0	46.0 47.0
	Unsecured Loans	0	0	0	0	47.0
	Other long term liabilities	20, 344, 945		0	0	49.0
	Total long term liabilities (sum of lines 46 thru 49)	20, 344, 945		0	0	50.0
1.00	Total liabilities (sum of lines 45 and 50)	29, 821, 244	0	0	0	51.0
2.00	CAPI TAL ACCOUNTS General fund balance	-9,023,672				52.0
	Specific purpose fund	- 9, 023, 072	0			53.0
	Donor created - endowment fund balance - restricted		, , , , , , , , , , , , , , , , , , ,	0		54.0
5.00	Donor created - endowment fund balance - unrestricted			0		55.C
	Governing body created - endowment fund balance			0	-	56.0
	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement				0	57.0 58.0
8.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	00.0
9.00	Total fund balances (sum of lines 52 thru 58)	-9, 023, 672	о	0	0	59.0
	Total liabilities and fund balances (sum of lines 51 and	20, 797, 572		0	0	

	I Financial Systems PA MENT OF CHANGES IN FUND BALANCES	RKVIEW WABASH H	Provider CC	CN: 15-1310			u of Form CMS Worksheet G Date/Time Pi 5/26/2023 3	-1 rep	ared:
		General	Fund	Speci al	Purpos	se Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENT Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-8, 549, 279 -98, 029 -8, 647, 308 -8, 647, 308 0 -8, 647, 308 376, 364 -9, 023, 672		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 19.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund	_				
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0			0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENT	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 18.00
16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0			0 0	0 0	0 0	0 0

ATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	l: 15-1310		/01/2022	Worksheet G- Parts I & II Date/Time Pr 5/26/2023 3:	repare
	Cost Center Description		Inpati ent	Outp	oati ent	Total	
			1.00	2	2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
00	Hospi tal		8, 420, 90	53		8, 420, 96	
00	SUBPROVIDER - IPF						2.
00	SUBPROVIDER - IRF						3.
00	SUBPROVIDER						4.
00	Swing bed - SNF			0			0 5.
00	Swing bed - NF			0			0 6.
00	SKILLED NURSING FACILITY						7.
00	NURSING FACILITY						8.
00	OTHER LONG TERM CARE						9.
0. 00	Total general inpatient care services (sum of lines 1-9)		8, 420, 90	53		8, 420, 96	3 10.
	Intensive Care Type Inpatient Hospital Services						
. 00	I NTENSI VE CARE UNI T						11.
2.00	CORONARY CARE UNIT						12.
3.00	BURN INTENSIVE CARE UNIT						13.
. 00	SURGI CAL INTENSI VE CARE UNI T						14.
5.00	OTHER SPECIAL CARE (SPECIFY)			_			15.
o. 00	Total intensive care type inpatient hospital services (sum of I	ines		0			0 16.
	11-15)		0 400 0			0 400 04	0 47
. 00	Total inpatient routine care services (sum of lines 10 and 16)		8, 420, 90			8, 420, 96	
3.00	Ancillary services		13, 501, 54		1,832,787	138, 334, 32	
9.00	Outpatient services		1, 409, 84		1, 226, 537	42, 636, 37	
	RURAL HEALTH CLINIC			0	-1, 417	-1, 41	
). 01	RURAL HEALTH CLINIC II				3, 144, 872		
	RURAL HEALTH CLINIC III				9, 982, 731	9, 982, 73	
. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		0 21.
2.00	HOME HEALTH AGENCY			~	0		22.
8.00	AMBULANCE SERVICES CMHC			0	0		0 23.
. 00 . 00							24.
b. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						25.
. 00 . 00	Other Patient Service Revenue		152, 33	20	375, 215	527, 55	
. 00 . 01	Other Patient Service Revenue - NRCCs		-8, 5		1, 153, 923	1, 145, 39	
3.00	Total patient revenues (sum of lines 17-27)(transfer column 3 f	o Wkst	23, 476, 1), 714, 648	204, 190, 80	
. 00	G-3, Line 1)	.o wkst.	20, 470, 10	100	, , , , , 040	204, 170, 00	2 20.
	PART II - OPERATING EXPENSES	I					
. 00	Operating expenses (per Wkst. A, column 3, line 200)			61	1, 333, 934		29.
0. 00	NONALLOWABLE HOME OFFICE INTEREST		539, 03	38			30.
. 00				0			31.
2. 00				0			32.
3. 00				0			33.
. 00				0			34.
5.00				0			35.
. 00	Total additions (sum of lines 30-35)				539, 038		36.
. 00	DEDUCT (SPECIFY)			0			37.
8.00				0			38.
0. 00				0			39.
0. 00				0			40.
. 00				0			41.
2. 00	Total deductions (sum of lines 37-41)				0		42.
8.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		61	I, 872, 972		43.
	to Wkst. G-3, line 4)						

517(1 Em	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1310	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
				5/26/2023 3:0	
			-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	o 28)		1.00 204,190,802	1.00
2.00	Less contractual allowances and discounts on patients' account			143, 007, 542	
3.00	Net patient revenues (line 1 minus line 2)	13		61, 183, 260	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		61, 872, 972	
5.00	Net income from service to patients (line 3 minus line 4)	43)		-689, 712	
	OTHER INCOME			007,712	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			6, 286	10.00
11.00	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			330, 691	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other t	han patients		46, 136	
	Revenue from sale of drugs to other than patients				17.00
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			6, 457	
	Rental of vending machines			0	21.00
	Rental of hospital space			126, 394	
	Governmental appropriations			143, 899	
	OTHER (SPECIFY)			0	
	Misc Revenue			-70, 567	
	COVI D-19 PHE Fundi ng			0	24.50
	Total other income (sum of lines 6-24)			589, 296	
	Total (line 5 plus line 25)			-100, 416	
27.00	LOSS ON DISPOSAL OF ASSETS			-2, 387	
	Total other expenses (sum of line 27 and subscripts)		1	-2, 387	28.00

	Systems PA	RKVIEW WABASH		CN: 15-1310	Dor	ri od:	u of Form CMS-2 Worksheet M-1	
VALISIS UN HUSP	TAE-BASED KIIC/TUIC COSTS		FIOVIDEI C	CN. 15-1510		om 01/01/2022	WULKSHEEL M-1	
			Component	CCN: 15-8541	То	12/31/2022	Date/Time Pre	
						RHC II	5/26/2023 3:0	19 pm
		Compensati on	Other Costs	Total (col	1 R	Reclassi fi cat	Reclassi fied	
		compensati on	01101 00313	+ col. 2	' '`	i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
	EALTH CARE STAFF COSTS							
00 Physi ci an		489, 044	102, 168	591, 2		0	591, 212	
	Assi stant	0	0		0	0	0	
00 Nurse Prac		217, 312	45, 399	262, 7	11	0	262, 711	
00 Visiting I		0	0		0	0	0	
00 Other Nurs		336, 570	70, 314	406, 8		0	406, 884	
	Psychol ogi st	0	0		0	0	0	
	Social Worker	0	0		0	0	0	1
	/ Techni ci an	0		202.4	0	0	0	
	lity Health Care Staff Costs (sum of lines 1 through 9)	251,009	52, 439			0	303, 448	
	Services Under Agreement	1, 293, 935	270, 320	1, 304, 23	55 0	0	1, 564, 255 0	
	Supervision Under Agreement	0	0		0	0	0	
	supervision under Agreement	0	0		0	0	0	1
	(sum of lines 11 through 13)	0	0		0	0	0	
5.00 Medical Su		0	233, 018	233, 0	18	0	233, 018	
	ation (Health Care Staff)	0	4, 656			0	4, 656	
	on-Medical Equipment	0	.,		0	0	0	
	nal Liability Insurance	0	0		0	ō	0	
	th Care Costs	0	1, 324	1, 3	24	0	1, 324	19.
0.00 Allowable	GME Costs							20.
.00 Subtotal	(sum of lines 15 through 20)	0	238, 998	238, 9	98	0	238, 998	21.
2.00 Total Cos ⁻	of Health Care Services (sum of	1, 293, 935	509, 318	1, 803, 2	53	0	1, 803, 253	22.
	14, and 21)							
	R THAN RHC/FOHC SERVICES			1				
3.00 Pharmacy		0	0		0	0	0	
1.00 Dental		0	0		0	0	0	
5.00 Optometry		0	1 500	0.7	0	0	0	
5.01 Tel eheal th 5.02 Chronic Ca		7, 219	1, 508	8, 72		0	8, 727	
	are Management	0	0		0	0	0	
	nonreimbursable costs ble GME costs	0	U		0	0	0	26. 27.
	reimbursable Costs (sum of lines 23	7, 219	1, 508	8, 7:	27	0	8, 727	
through 2		7,217	1, 500	0,7.	21	0	0,727	20.
FACILITY C								
0.00 Facility		0	151, 590	151, 5	90	0	151, 590	29.
,	ative Costs	52, 935	511, 941			0	564, 876	
	lity Overhead (sum of lines 29 and		663, 531			Ō	716, 466	
30)								
	lity costs (sum of lines 22, 28	1, 354, 089	1, 174, 357	2, 528, 4	46	0	2, 528, 446	32.
and 31)								

	5	RKVIEW WABASH				u of Form CMS	
ANALYSI	S OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO	CN: 15-1310	Period: From 01/01/2022	Worksheet M-	1
			Component (CCN: 15-8541	To 12/31/2022	Date/Time Pr 5/26/2023 3:	
					RHC II		
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00				
E	ACILITY HEALTH CARE STAFF COSTS	6.00	7.00				-
	Physician	0	591, 212				1.0
	Physi ci an Assi stant	0	0,71,212				2.0
	Nurse Practitioner	0	262, 711				3.0
	Visiting Nurse	0	0				4.0
	Other Nurse	0	406, 884				5.0
5.00	Clinical Psychologist	0	0				6.0
7.00	Clinical Social Worker	0	0				7.0
3. OO I	Laboratory Techni ci an	0	0				8.0
0.00	Other Facility Health Care Staff Costs	0	303, 448				9.
0.00	Subtotal (sum of lines 1 through 9)	0	1, 564, 255				10.
	Physician Services Under Agreement	0	0				11.
2.00	Physician Supervision Under Agreement	0	0				12.
	Other Costs Under Agreement	0	0				13.
	Subtotal (sum of lines 11 through 13)	0	0				14.
	Medical Supplies	0	233, 018				15.
	Transportation (Health Care Staff)	0	4, 656				16.
	Depreciation-Medical Equipment	0	0				17.
	Professional Liability Insurance	0	0				18.
	Other Health Care Costs	0	1, 324				19.
	Allowable GME Costs	0					20.
	Subtotal (sum of lines 15 through 20)	0	238, 998				21.0
	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1, 803, 253				22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						_
	Pharmacy	0	0				23.0
	Dental	0	0				24.0
	Optometry	0	0				25.
	Tel eheal th	0	8, 727				25.
	Chronic Care Management	0	0				25.
	All other nonreimbursable costs	0	0				26.
27.00	Nonallowable GME costs						27.
28.00	Total Nonreimbursable Costs (sum of lines 23	0	8, 727				28.0
	through 27)						
F	ACILITY OVERHEAD						
	Facility Costs	0	151, 590				29.
	Administrative Costs	-978	563, 898				30.
	Total Facility Overhead (sum of lines 29 and	-978	715, 488				31.0
1	30)						
	Total facility costs (sum of lines 22, 28	-978	2, 527, 468				32.0
i	and 31)						

Compensation Other Costs Total (co. 1 + col. 2) Reclassifice ions 1.00 2.00 3.00 4.00 Physician Assistant 0 0 0 0 1.00 Physician 0 0 0 0 0 1.00 Physician Assistant 0 <th></th> <th></th> <th>RKVIEW WABASH</th> <th></th> <th></th> <th>-</th> <th></th> <th>u of Form CMS-2</th> <th></th>			RKVIEW WABASH			-		u of Form CMS-2	
Component CCN: 15-8542 To 12/31/20. RHC LII RHC LII RHC LII Compensation Other Costs Total (col. 2) Reclassific I.00 Physician Assistant 0 2.00 3.00 4.00 I.00 Physician Assistant 0 0 0 0 0 I.00 Visiting Nurse 0 0 0 0 0 0 0.00 Nurse Practitioner 719.058 328.107 1.047.165 0 0 0 0.00 Other Nurse 753.687 128.625 882.312 0 0 0.00 Other Facility Health Care Staff Costs 394.207 308.793 703.000 0 0.00 Suboral (sum of lines 11 through 9) 2.536.219 879.742 3.415.961 0	٩LY	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1310			Worksheet M-1	
Compensation Other Costs Total (col. 1 + col. 2) Reclassifications 1.00 2.00 3.00 4.00 1.00 Physician 669,267 114,217 783,484 2.00 Physician Assistant 0 0 0 0 3.00 Nurse Practitioner 719,058 328,107 1.047,165 3.00 Clinical Social Worker 0 0 0 0 0.00 Clinical Social Worker 0 0 0 0 0.00 Other Costs Under Agreement 0 0 0 0 0.01 Deprication Kargement 0 0 0 0 0.01 Deprication Services Under Agreement 0 0 0 0 0.01 Deprication Services Under Agreement 0 0 0 0 0 0.01 Depreciation-Medical Equipment 0 0 0 0 0 0 0 0 0 0 0 0 0 0				Component	CCN: 15-8542			Date/Time Pre 5/26/2023 3:0	
FACILITY HEALTH CARE STAFF COSTS 1.00 2.00 3.00 4.00 1.00 Physician 669,267 114,217 783,484 0 0.00 Nurse Practitioner 719,058 328,107 1.047,165 0 0 3.00 Other Nurse 0 0 0 0 0 0 5.00 Other Nurse 0 0 0 0 0 0 0 0 6.00 Clinical Social Worker 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>RHC III</td><td></td><td></td></td<>							RHC III		
FACILITY HEALTH CARE STAFF COSTS 1.00 2.00 3.00 4.00 Physician 669,267 114,217 783,484 2.00 Physician Assistant 0 0 0 3.00 Nurse 719,058 328,107 1,047,165 4.00 Visiting Nurse 0 0 0 0 5.00 Other Nurse 753,687 128,625 882,312 0 0.0 Clinical Sychologist 0 0 0 0 0 7.00 Clinical Sychologist 0 0 0 0 0 10.00 Subtotal (sum of lines 1 through 9) 2,536,219 879,742 3,415,961 11.00 Physician Services Under Agreement 0 0 0 0 12.00 Physician Services Under Agreement 0 0 0 0 13.00 Other Agreement 0 0 0 0 0 14.00 Subotal (sum of lines 11 through 13) 0 0			Compensati on	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 669, 267 114, 217 783, 484 0.00 Nurse practitioner 719, 058 328, 107 1, 047, 165 0.01 Other Nurse 0 0 0 0 0.02 Other Nurse 753, 687 128, 625 882, 312 0 0.01 Clinical Social Worker 0 0 0 0 0 0.02 Other Facility Health Care Staff Costs 394, 207 308, 793 703, 000 0 <t< td=""><td></td><td></td><td></td><td></td><td>+ col. 2)</td><td></td><td>i ons</td><td>Trial Balance</td><td></td></t<>					+ col. 2)		i ons	Trial Balance	
FACILITY HEALTH CARE STAFF COSTS 1.00 Physic ian 669, 267 114, 217 783, 484 2.00 Physic ian Assistant 0 0 0 3.00 Nurse Practitioner 719, 058 328, 107 1, 047, 165 4.00 Visiting Murse 0 0 0 0 5.00 Clinical Social Worker 0 0 0 0 0.01 Colinical Social Worker 0 0 0 0 0.00 Uboratory Technician 0 0 0 0 0 0.00 Other Facility Health Care Staff Costs 394, 207 308, 793 703, 000 0.00 Other Facility Health Care Staff 0 0 0 0 0.00 Other Casts Under Agreement 0 0 0 0 11.00 Physic ian Supervision Under Agreement 0 0 0 0 12.00 Physic ansupervision Under Agreement 0 0 0 0 10.00 De								(col. 3 +	
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 669, 267 114, 217 783, 484 0.00 Nurse practitioner 719, 058 328, 107 1, 047, 165 0.01 Other Nurse 0 0 0 0 0.02 Other Nurse 753, 687 128, 625 882, 312 0 0.01 Clinical Social Worker 0 0 0 0 0 0.02 Other Facility Health Care Staff Costs 394, 207 308, 793 703, 000 0 <t< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td>2.00</td><td></td><td>4.00</td><td><u>col.4)</u> 5.00</td><td></td></t<>			1.00	2.00	2.00		4.00	<u>col.4)</u> 5.00	
1.00 Physician 669,267 114,217 783,484 2.00 Physician Assistant 0 0 0 3.00 Nurse Practitioner 719,058 328,107 1,047,165 3.00 Visiting Nurse 0 0 0 0 5.00 Clinical Psychologist 0 0 0 0 5.00 Clinical Social Worker 0 0 0 0 6.00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 7.00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 7.00 Deprivician Supervision Under Agreement 0 0 0 0 7.00 Depreciation-Medical Equipment 0 0 0		FACILLTY HEALTH CARE STAFE COSTS	1.00	2.00	3.00		4.00	5.00	
Physician Assistant 0 0 0 0 0.00 Nurse Practitioner 719,058 328,107 1,047,165 0.01 Visiting Nurse 0 0 0 0.02 Other Nurse 753,687 128,625 882,312 0.01 Clinical Social Worker 0 0 0 0.02 Datoratory Technician 0 0 0 0.03 Subtotal (sum of lines 1 through 9) 2,536,219 879,742 3,415,961 0.04 Other Agreement 0 0 0 0 0.05 Other Agreement 0 0 0 0 0.00 Other Health Care Staff 0 0 0 0 0.00 Other Stunder Agreement 0 0 0 0 1.00 Physician Services Under Agreement 0 0 0 0 1.00 Depreciation -Medical Equipment 0 0 0 0 1.00 Derdesional Liability Insurance	00		669 267	114 217	783.4	84	0	783, 484	1.0
100 Nurse Practitioner 719,058 328,107 1,047,165 00 Visiting Nurse 0 0 0 00 Clinical Sychologist 0 0 0 00 Clinical Social Worker 0 0 0 00 Clinical Social Worker 0 0 0 00 Suboratory Technician 0 0 0 00 Chincal Social Worker 0 0 0 00 Suboratory Technician 0 0 0 00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 00 Obtotal (sum of lines 1 through 9) 2,536,219 879,742 0 0 0 Obtor Costs Under Agreement 0 0 0 0 0 0 Uher Costs Under Agreement 0 0 0 0 0 0 Uher Costs Under Agreement 0 0 0 0 0 0 Mercessional Liability Insura			007,207	0	700, 1		0	0	
00 Visiting Nurse 0 0 0 00 Other Nurse 753,687 128,625 882,312 00 Clinical Psychologist 0 0 0 00 Clinical Social Worker 0 0 0 00 Laboratory Technician 0 0 0 00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 00 Subtotal (sum of lines 1 through 9) 2,536,219 879,742 3,415,961 1.00 Physician Supervision Under Agreement 0 0 0 0 2.00 Physician Supervision Under Agreement 0 0 0 0 3.00 Other Costs Under Agreement 0 0 0 0 0 3.00 Physician Supprision Under Agreement 0 <td></td> <td></td> <td>719.058</td> <td>328, 107</td> <td>1.047.1</td> <td>65</td> <td>0</td> <td>1,047,165</td> <td></td>			719.058	328, 107	1.047.1	65	0	1,047,165	
00 Other Nurse 753,687 128,625 882,312 00 Clinical Psychologist 0 0 0 00 Linical Social Worker 0 0 0 00 Unical Social Worker 0 0 0 00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 00 Other Sacility Health Care Staff Costs 394,207 308,793 703,000 00 Other Costs Under Agreement 0 0 0 0 00 Physician Supervision Under Agreement 0 0 0 0 010 Subtotal (sum of lines 11 through 13) 0 0 0 0 010 Horable Cal Supplies 0 597,249 597,249 597,249 020 Physician Supervision Under Agreement 0 0 0 0 010 Horable Cal Supplies 0 7,728 7,728 7,728 020 Physician Supervisional Liability Insurance 0 0 0			0	0	.,	0	0	0	
0.00 Clinical Psychologist 0 0 0 0.00 Clinical Social Worker 0 0 0 0.01 Deboratory Technician 0 0 0 0.02 Obtoratory Technician 0 0 0 0.00 Subtotal (sum of lines 1 through 9) 2,536,219 879,742 3,415,961 0.01 Ophysician Supervision Under Agreement 0 0 0 0 0.01 Other Costs Under Agreement 0 0 0 0 0.01 Other Costs Under Agreement 0 0 0 0 0.01 Other Costs Under Agreement 0 0 0 0 0.02 Other Costs Under Agreement 0 0 0 0 0.02 Transportation (Health Care Staff) 0 7,728 7,728 7,728 0.00 Atlowable GME Costs 0 0 0 0 0 0.00 Other Health Care Staff) 0 0 0 0 <td></td> <td>5</td> <td>753, 687</td> <td>128,625</td> <td>882.3</td> <td>12</td> <td>0</td> <td>882, 312</td> <td></td>		5	753, 687	128,625	882.3	12	0	882, 312	
00 Laboratory Technician 0 0 0 0 00 Other Facility Health Care Staff Costs 394,207 308,793 703,000 00 Obtotal (sum of lines 1 through 9) 2,536,219 367,742 3,415,961 1.00 Physician Supervision Under Agreement 0 0 0 0 2.00 Physician Supervision Under Agreement 0 0 0 0 0.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 0.00 Subtotal (sum of lines 124 Equipment 0 0 0 0 0.00 Professional Liability Insurance 0 0 0 0 0.00 Professional Liability Care Costs 0 1,829 1,829 0 0.00 Other Health Care Services (sum of 2,536,219 1,486,548 4,022,767 0 1.00 Subtotal (sum of lines 15 through 20) 0 6066,806 606,806 606,806 0.0 Othat Care Services (sum of 1,797 0 0 0 0 </td <td>00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td>	00		0	0			0	0	
0.00 Other FacIlity Health Care Staff Costs 394,207 308,793 703,000 0.00 Subtotal (sum of lines 1 through 9) 2,536,219 879,742 3,415,961 1.00 Physician Supervision Under Agreement 0 0 0 0.01 Subtotal (sum of lines 11 through 13) 0 0 0 0.02 Wedical Supplies 0 597,249 597,249 0.00 Transportation (Heal th Care Staff) 0 7,728 7,728 0.00 Transportation (Heal th Care Staff) 0 0 0 0.00 Transportation (Heal th Care Staff) 0 0 0 0.00 Transportation (Heal th Care Staff) 0 0 0 0.00 Professional Liability Insurance 0 0 0 0.00 All owable GME Costs 0 1,829 1,829 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Heal th Care Services (sum of 2,536,219 1,486,548 4,022,767			0	0		0	0	0	7.(
0.00 Subtotal (sum of lines 1 through 9) 2, 536, 219 879, 742 3, 415, 961 1.00 Physician Services Under Agreement 0 0 0 0.00 Physician Supervision Under Agreement 0 0 0 0.00 Subtotal (sum of lines 11 through 13) 0 0 0 0.00 Bedical Supplies 0 597, 249 597, 249 0.00 Transportation (Heal th Care Staff) 0 7, 728 7, 728 7.00 Depreciation-Medical Equipment 0 0 0 0.00 Professional Liability Insurance 0 0 0 0.00 Professional Liability Insurance 0 0 0 0.00 Allowable GME Costs 0 1, 829 1, 829 0.00 Allowable GME Costs 0 0 0 1.00 Subtotal (sum of lines 15 through 20) 0 666, 806 606, 806 2.00 Total Cost of Heal th Care Services (sum of 1, 703 1, 997 13, 700 0 5.00 Optometry 0 0 0 0 5.01 </td <td>00</td> <td>Laboratory Techni ci an</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>8.</td>	00	Laboratory Techni ci an	0	0		0	0	0	8.
0.00 Subtotal (sum of lines 1 through 9) 2, 536, 219 879, 742 3, 415, 961 1.00 Physician Services Under Agreement 0 0 0 0.00 Other Costs Under Agreement 0 0 0 0.01 Subtotal (sum of lines 11 through 13) 0 0 0 0.01 Subtotal (sum of lines 11 through 13) 0 0 0 0.01 Fransportation (Health Care Staff) 0 7,728 7,728 7.00 Depreciation-Medical Equipment 0 0 0 0.00 Professional Liability Insurance 0 0 0 0.01 Subtotal (sum of lines 15 through 20) 0 606, 806 606, 806 2.00 Nathowable GME Costs 0 1, 829 1, 829 0.00 Subtotal (sum of lines 15 through 20) 0 606, 806 606, 806 2.00 Total Cost of Health Care Services (sum of 2, 536, 219 1, 486, 548 4, 022, 767 11nes 10, 14, and 21) 0 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0	00	Other Facility Health Care Staff Costs	394, 207	308, 793	703, 00	00	0	703, 000	9.
2.00 Physician Supervision Under Agreement 0 0 3.00 Other Costs Under Agreement 0 0 4.00 Subtotal (sum of lines 11 through 13) 0 0 5.00 Medical Supplies 0 597, 249 6.00 Transportation (Heal th Care Staff) 0 7, 728 7, 728 7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 0 0 9.00 Other Heal th Care Costs 0 1, 829 1, 829 0.00 Subtotal (sum of lines 15 through 20) 0 606, 806 606, 806 2.00 Tata Cost of Heal th Care Services (sum of 2, 536, 219 1, 486, 548 4, 022, 767 1 lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 Dental 0 0 0 0 0 1 Teleheal th 11, 703 1, 997 13, 700 0 0 5.01 Teleheal th 111, 703 <td>00</td> <td></td> <td>2, 536, 219</td> <td>879, 742</td> <td>3, 415, 9</td> <td>61</td> <td>0</td> <td>3, 415, 961</td> <td>10.</td>	00		2, 536, 219	879, 742	3, 415, 9	61	0	3, 415, 961	10.
3.00 Other Costs Under Agreement 0 0 0 4.00 Subtotal (sum of Lines 11 through 13) 0 0 0 5.00 Medical Supplies 0 597, 249 597, 249 6.00 Transportation (Heal th Care Staff) 0 7, 728 7, 728 7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 1, 829 1, 829 9.00 Atlowable GME Costs 0 1, 829 1, 829 1.00 Subtotal (sum of Lines 15 through 20) 0 606, 806 606, 806 2.00 Total Cost of Heal th Care Services (sum of 2, 536, 219 1, 486, 548 4, 022, 767 1 ines 10, 14, and 21) 0 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 3.00 Pharmacy 0 0 0 0 5.01 Tel eheal th 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 0 5.02 Chronic Care Manag	00	Physician Services Under Agreement	0	0		0	0	0	
4.00 Subtotal (sum of lines 11 through 13) 0 0 0 5.00 Medical Supplies 0 597, 249 597, 249 6.00 Transportation (Heal th Care Staff) 0 7,728 7,728 7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 0 0 9.00 Other Heal th Care Costs 0 1,829 1,829 0.00 Allowable GME Costs 0 606,806 606,806 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Heal th Care Services (sum of 2,536,219 1,486,548 4,022,767 1.1 ines 10, 14, and 21) 0 0 0 0 Costs OTHER THAN RHC/FOHC SERVICES Pharmacy 0 0 0 5.01 Teleheal th 11,703 1,997 13,700 FACILITY OVERHEAD FACILITY OVERHEAD O 0 433,245 433,245 1.00 Total Nonreimbursable	00	Physician Supervision Under Agreement	0	0		0	0	0	12.
5.00 Medical Supplies 0 597, 249 597, 249 6.00 Transportation (Heal th Care Staff) 0 7, 728 7, 728 7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 0 0 9.00 Other Heal th Care Costs 0 1, 829 1, 829 0.00 Allowable GME Costs 0 606, 806 606, 806 2.00 Total Cost of Heal th Care Services (sum of 2, 536, 219 1, 486, 548 4, 022, 767 1 ines 10, 14, and 21) 0 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 3.00 Pharmacy 0 0 0 0 5.01 Teleheal th 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 0 6.00 All other nonreimbursable costs 0 0 0 0 7.00 Nonallowable GME costs 0 0 0 0 8.00 Total Nonreimbursab	00	Other Costs Under Agreement	0	0		0	0	0	13.
6.00 Transportation (Health Care Staff) 0 7,728 7,728 7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 0 0 9.00 Other Health Care Costs 0 1,829 1,829 0.00 Allowable GME Costs 0 606,806 606,806 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Health Care Services (sum of 2,536,219 1,486,548 4,022,767 1.01 Innes 10, 14, and 21) 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 3.00 Pharmacy 0 0 0 4.00 Dental 0 0 0 5.00 Optometry 0 0 0 0 5.01 Tel heal th 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 0 6.00 All other nonreimbursable costs 0 0 0 0	00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.
7.00 Depreciation-Medical Equipment 0 0 0 8.00 Professional Liability Insurance 0 0 0 9.00 Other Health Care Costs 0 1,829 1,829 0.00 Allowable GME Costs 0 606,806 606,806 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Health Care Services (sum of 2,536,219 1,486,548 4,022,767 Ines 10, 14, and 21) 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 3.00 Pharmacy 0 0 0 0 0 0 0 0 5.00 Optometry 0 0 0 5.01 Telehealth 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonal lowable GME costs 0 433,245 433,245 8.00 Total Nonreimbursable Costs (sum of lin	00	Medical Supplies	0	597, 249	597, 24	49	0	597, 249	15.
8.00 Professional Liability Insurance 0 0 0 9.00 Other Health Care Costs 0 1,829 1,829 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Health Care Services (sum of 2,536,219 1,486,548 4,022,767 1 ines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 0 0 0 2.00 Dental 0 0 0 0 5.00 Optometry 0 0 0 0 5.01 Telehealth 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonal Iowable GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11,703 1,997 13,700 FACILITY OVERHEAD 9.00 Facility Costs 0 433,245 433,245 9.00 Facility Osts 0 433,245 433,245 433,245 1	00		0	7, 728	7,7	28	0	7, 728	16.
9.00 Other Heal th Care Costs 0 1,829 1,829 0.00 Allowable GME Costs 0 606,806 606,806 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Heal th Care Services (sum of 2,536,219 1,486,548 4,022,767 Ines 10, 14, and 21) 0 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 3.00 Pharmacy 0 0 0 0 5.01 Teleheal th 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonal Iowable GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11,703 1,997 13,700 FACI LI TY OVERHEAD 9.00 Faci Li TY OVERHEAD 0 433,245 433,245 9.00 Faci Li ty Costs 0 433,245 433,245 433,245 1.00 <			0	0		0	0	0	
0.00 Allowable GME Costs 0 606,806 606,806 1.00 Subtotal (sum of lines 15 through 20) 0 606,806 606,806 2.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 1,486,548 4,022,767 COSTS OTHER THAN RHC/FOHC SERVICES 3.00 Pharmacy 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 3.00 Pharmacy 0 0 0 4.00 Dental 0 0 0 0 5.01 Telehealth 11,703 1,997 13,700 0 0 5.02 Chronic Care Management 0 0 0 0 0 0 6.00 All other nonreimbursable costs 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0		0	0	0	
1.00 Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 606, 806 4, 022, 767 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 3.00 Pharmacy 0 0 0 0 0 0 0 0 5.00 Optometry 0 0 0 5.01 Telehealth 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11, 703 1, 997 13, 700 7.01 Nonal lowable GME costs 0 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11, 703 1, 997 13, 700 7.02 Facility Costs 0 433, 245 433, 245 9.00 Facility Costs 0 433, 245 433, 245 9.00 Facility Costs 0 433, 245 433, 245 9.00 Total Facility Over			0	1, 829	1, 82	29	0	1, 829	
2.00 Total Cost of Health Care Services (sum of Lines 10, 14, and 21) 1, 486, 548 4, 022, 767 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 0 3.00 Pharmacy 0 0 0 0 4.00 Dental 0 0 0 0 5.01 Telehealth 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonal lowable GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11, 703 1, 997 13, 700 FACILITY OVERHEAD 70 13, 700 13, 700 13, 700 9.00 Facility Costs 0 433, 245 433, 245 9.00 Facility Costs 0 433, 245 433, 245 0.00 Administrative Costs 804, 356 1, 377, 467 2, 181, 823 1.00 Total Facility Overhead (sum of lines 29 and									20.
lines 10, 14, and 21) O COSTS OTHER THAN RHC/FQHC SERVICES 0 3.00 Pharmacy 0 0 Dental 0 0.00 Dental 0 0.01 Dental 0 0.02 Optometry 0 0.01 Teleheal th 11,703 1.02 Chronic Care Management 0 0.02 Chronic Care Management 0 0.03 Optometry 0 0 0.04 All other nonreimbursable costs 0 0 0.03 Nonal Iowable GME costs 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11,703 1,997 13,700 through 27) Tail rough 27 13,700 FACILLITY OVERHEAD 0 433,245 433,245 0.00 Facility Costs 0 433,245 433,245 0.00 Administrative Costs 804,356 1,377,467 2,181,823 1.00 Total Facility Overhead (sum of lines 29 and <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>0</td><td>606, 806</td><td></td></td<>			0				0	606, 806	
COSTS OTHER THAN RHC/FOHC SERVICES 3.00 Pharmacy 0 0 0 4.00 Dental 0 0 0 0 5.00 Optometry 0 0 0 0 0 5.01 Teleheal th 11,703 1,997 13,700 0 0 6.00 All other nonreimbursable costs 0 0 0 0 0 7.00 Nonal I owable GME costs 0 0 0 0 0 7.00 Nonal I owable Costs (sum of Lines 23 11,703 1,997 13,700 13,700 7.00 Nonal I owable Costs (sum of Lines 23 11,703 1,997 13,700 7.00 Total Nonreimbursable Costs (sum of Lines 23 11,703 1,997 13,700 7.00 FACILLITY OVERHEAD 7 433,245 433,245 433,245 9.00 Facility Costs 0 433,245 433,245 2,181,823 1.00 Total Facility Overhead (sum of Lines 29 and 804,356 1	00		2, 536, 219	1, 486, 548	4, 022, 7	67	0	4, 022, 767	22.
3.00 Pharmacy 0 0 0 4.00 Dental 0 0 0 5.00 Optometry 0 0 0 5.01 Teleheal th 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonallowable GME costs 0 0 0 7.00 Nonallowable GME costs 0 0 0 7.00 Total Nonreimbursable Costs (sum of lines 23 11, 703 1, 997 13, 700 7.00 FACILITY OVERHEAD 7 1, 997 13, 700 FACILITY OVERHEAD 7 433, 245 433, 245 9.00 Facility Costs 0 433, 245 433, 245 0.00 Administrative Costs 804, 356 1, 377, 467 2, 181, 823 1.00 Total Facility Overhead (sum of lines 29 and 804, 356 1, 810, 712 2, 615, 068		lines 10, 14, and 21)							
4.00 Dental 0 0 0 5.00 Optometry 0 0 0 5.01 Tel eheal th 11, 703 1, 997 13, 700 5.02 Chronic Care Management 0 0 0 0 6.00 All other nonreimbursable costs 0 0 0 0 7.00 Nonallowable GME costs 0 0 0 0 8.00 Total Nonreimbursable costs (sum of lines 23 11, 703 1, 997 13, 700 Horough 27) FACI LLI TY OVERHEAD 9.00 Facility Costs 0 433, 245 433, 245 9.00 Facility Costs 0 433, 245 433, 245 433, 245 1.00 Total Facility Overhead (sum of lines 29 and 804, 356 1, 810, 712 2, 615, 068	00		0	0		0	0	0	23.
5.00 Optometry 0 0 0 5.01 Teleheal th 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonal I owable & GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11,703 1,997 13,700 FACI LLI TY OVERHEAD		5	0			-	0	0	
5.01 Telehealth 11,703 1,997 13,700 5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonallowable GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 11,703 1,997 13,700 FACILITY OVERHEAD 70 13,700 9.00 Facility Costs 0 433,245 433,245 433,245 1,377,467 9.00 Administrative Costs 804,356 1,377,467 2,181,823 1,00 1.00 Total Facility Overhead (sum of lines 29 and 804,356 1,810,712 2,615,068			0			0	0	0	
5.02 Chronic Care Management 0 0 0 6.00 All other nonreimbursable costs 0 0 0 7.00 Nonallowable GME costs 0 0 0 8.00 Total Nonreimbursable Costs (sum of lines 23 through 27) 11,703 1,997 13,700 FACILITY OVERHEAD 9.00 Facility Costs 0 433,245 433,245 9.00 Administrative Costs 804,356 1,377,467 2,181,823 1.00 Total Facility Overhead (sum of lines 29 and 804,356 1,810,712 2,615,068			11 703	1 997	13.70	00	0	13,700	
6.00All other nonreimbursable costs0007.00Nonallowable GME costs11,7031,99713,7008.00Total Nonreimbursable Costs (sum of lines 23 through 27)11,7031,99713,700FACILITY OVERHEAD9.00Facility Costs0433,245433,2450.00Administrative Costs804,3561,377,4672,181,8231.00Total Facility Overhead (sum of lines 29 and804,3561,810,7122,615,068			0	0	10, 1		0	0	
7.00 Nonallowable GME costs 8.00 Total Nonreimbursable Costs (sum of lines 23 through 27) 11,703 1,997 13,700 FACILITY OVERHEAD Facility Costs 0 433,245 433,245 9.00 Facility Costs 0 433,245 433,245 0.00 Administrative Costs 804,356 1,377,467 2,181,823 1.00 Total Facility Overhead (sum of lines 29 and 804,356 1,810,712 2,615,068			0	0		0	0	0	
8. 00 Total Nonreimbursable Costs (sum of lines 23 through 27) 11, 703 1,997 13, 700 FACILITY OVERHEAD			-			-	-	-	27.
FACILITY OVERHEAD 9.00 Facility Costs 0 433, 245 433, 245 0.00 Administrative Costs 804, 356 1, 377, 467 2, 181, 823 1.00 Total Facility Overhead (sum of lines 29 and 804, 356 1, 810, 712 2, 615, 068			11, 703	1, 997	13, 70	00	0	13, 700	
9.00 Facility Costs 0 433, 245 433, 245 0.00 Administrative Costs 804, 356 1, 377, 467 2, 181, 823 1.00 Total Facility Overhead (sum of lines 29 and 804, 356 1, 810, 712 2, 615, 068								-,	
0.00 Administrative Costs 804, 356 1, 377, 467 2, 181, 823 1.00 Total Facility Overhead (sum of lines 29 and sold sold sold sold sold sold sold sol		FACILITY OVERHEAD							
1.00 Total Facility Overhead (sum of lines 29 and 804,356 1,810,712 2,615,068			-				0	433, 245	
							0	2, 181, 823	
130)	00		804, 356	1, 810, 712	2, 615, 0	68	0	2, 615, 068	31.
		30)							
32.00 Total facility costs (sum of lines 22, 28 3, 352, 278 3, 299, 257 6, 651, 535 and 31)	00		3, 352, 278	3, 299, 257	6, 651, 5	35	0	6, 651, 535	32.

	Financial Systems PA S OF HOSPITAL-BASED RHC/FOHC COSTS	RKVI EW WABASH	Provider C	N. 1E 1210	Period:	u of Form CMS- Worksheet M-	
INAL 131	S OF HUSPITAL-DASED KHC/FUHC CUSTS				From 01/01/2022		
			Component	CCN: 15-8542	To 12/31/2022	Date/Time Pr 5/26/2023 3:	epareo
					RHC III	0/20/2020 0.	<u>o, biii</u>
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 + col. 6)				
		6.00	7.00				
F	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
	Physi ci an	0	783, 484				1.
	Physician Assistant	0					2.
00 1	Nurse Practitioner	0	1, 047, 165				3.
00	Visiting Nurse	0	0				4.
00 0	Other Nurse	0	882, 312				5.
00 0	Clinical Psychologist	0	0				6.
00	Clinical Social Worker	0	0				7.
	Laboratory Techni ci an	0	0				8.
00 0	Other Facility Health Care Staff Costs	0					9.
	Subtotal (sum of lines 1 through 9)	0	3, 415, 961				10.
	Physician Services Under Agreement	0	0				11.
	Physician Supervision Under Agreement	0	0				12.
. 00 0	Other Costs Under Agreement	0	0				13
	Subtotal (sum of lines 11 through 13)	0	0				14.
	Medical Supplies	0	597, 249				15.
	Transportation (Health Care Staff)	0	7, 728				16.
	Depreciation-Medical Equipment	0	0				17.
	Professional Liability Insurance	0	0				18
	Other Health Care Costs	0	1, 829				19
	Allowable GME Costs	0					20
	Subtotal (sum of lines 15 through 20)	0	606, 806				21
	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4, 022, 767				22.
	COSTS OTHER THAN RHC/FQHC SERVICES						-
	Pharmacy	0	0				23
	Dental	0					24
	Optometry	0					25.
	Tel eheal th	0	13, 700				25
	Chronic Care Management	0	0				25
	All other nonreimbursable costs	0	0				26.
. 00 1	Nonallowable GME costs						27.
. 00	Total Nonreimbursable Costs (sum of lines 23	0	13, 700				28.
ŀ	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0					29
	Administrative Costs	-483					30.
	Total Facility Overhead (sum of lines 29 and	-483	2, 614, 585				31.
	30)						
	Total facility costs (sum of lines 22, 28	-483	6, 651, 052				32.
i i i	and 31)						

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2022	Worksheet M-2	
			Component		To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			_	_	RHC II		
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	-	-	1	1		
00	Physi ci an	1.75					1.0
00	Physician Assistant	0.00					2.0
00	Nurse Practitioner	1.59					3.0
00	Subtotal (sum of lines 1 through 3)	3. 34			10, 689	12, 573	
00	Visiting Nurse	0.00				0	5.0
00	Clinical Psychologist	0.00				0	6.
00	Clinical Social Worker	0.00				0	7.0
01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
	onl y)						
00	Total FTEs and Visits (sum of lines 4	3.34	12, 573			12, 573	8.0
	through 7)						
00	Physician Services Under Agreements		0			0	9. (
				2011 050		1.00	
				RVICES		1 000 050	10.0
						1, 803, 253	
						8, 727	
2.00						1, 811, 980 0. 995184	
. 00	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) Cost of all services (excluding overhead) (sum of lines 10 and 11) Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						
. 00	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) Cost of all services (excluding overhead) (sum of lines 10 and 11) Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) Parent provider overhead allocated to facility (see instructions)						14.0
. 00		ty (see instru	ctions)			1, 711, 387	
	Total overhead (sum of lines 14 and 15)					2, 426, 875	
	Allowable GME overhead (see instructions)					0	17.
	Enter the amount from line 16					2, 426, 875	
J. 00	Overhead applicable to hospital-based RHC/F	JHC services (ine 13 x line '	18)		2, 415, 187	19.

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

00 Physician Assistant 0.00 0 2,100 0 2.00 00 Nurse Practitioner 4.50 33,531 2,100 9,450 3.00 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.00 00 Visiting Nurse 0.00 0 0 0 0.50 0.00 0 0.00 <th></th> <th>Financial Systems P ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC</th> <th>ARKVI EW WABASH SERVI CES</th> <th></th> <th></th> <th>Period:</th> <th>u of Form CMS-2 Worksheet M-2</th> <th></th>		Financial Systems P ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	ARKVI EW WABASH SERVI CES			Period:	u of Form CMS-2 Worksheet M-2	
VISITS AND PRODUCTIVITY Number of FTE Personnel Total Visits Productivity Standard (1) MI nimum Visits (col. 1 x col.3) Greater of col.4 VISITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 00 Physician 1.86 9,644 4.200 7.812 1.0 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 3.0 00 Clinical Sychologist 0.00 0								
Number of FTE Personnel Total Visits RHC III Creater of col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY 1.00 2.00 3.00 4.00 5.00 Positions 0.00 0.00 0 2.100 0 2.00 00 Physician Assistant 0.00 0 2.100 0 2.00 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 3.0 00 Clinical Psychologist 0.00 0 0 0 0.00 0 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0.00 0 0.00 0.00 0 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 <td< td=""><td></td><td></td><td></td><td>Component</td><td>CCN: 15-8542</td><td>To 12/31/2022</td><td></td><td></td></td<>				Component	CCN: 15-8542	To 12/31/2022		
Personnel Standard (1) Visits (col. 1 x col.3) col.2 or col.4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY						RHC III	0/20/2020 0.0	<i>y</i> pm
VISITS AND PRODUCTIVITY 1 x col. 3 col. 4 Position 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 00 Physician Assistant 0.00 0.00 2.00 0 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 2.00 0.00 9.450 3.00 3.00 4.3.175 4.3.175 4.3.175 4.3.175 4.00 7.00 0.00 <td< td=""><td></td><td></td><td>Number of FTE</td><td>Total Visits</td><td>Producti vi ty</td><td>Mi ni mum</td><td>Greater of</td><td></td></td<>			Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
I.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions I.00 2.00 3.00 4.00 5.00 00 Physician I.86 9.644 4.200 7.812 1.00 00 Physician Assistant 0.00 0 2.100 0 3.00 4.50 33.531 2.100 9.450 3.00 4.3,175 4.00 5.00 3.00 0 3.00 0.00 0 3.00 0.00 0 3.00 4.3,175 4.00 5.00 3.00 0.00 0 3.00			Personnel		Standard (1)	Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY Positions Positions						1 x col. 3)		
Positions .00 Physician 1.86 9,644 4,200 7,812 1.00 00 Physician Assistant 0.00 0 2,100 0 2.00 00 Nurse Practitioner 4,50 33,531 2,100 9,450 3.0 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.0 00 Visiting Nurse 0.00 0 0 5.0 5.00 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0.00 0.00 0 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			1.00	2.00	3.00	4.00	5.00	
00 Physician 1.86 9,644 4,200 7,812 1.0 00 Physician Assistant 0.00 0 2,100 0 2.00 00 Nurse Practitioner 4.50 33,531 2,100 9,450 3.0 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.0 00 Clinical Psychologist 0.00 0 0 0.6 0.6 6.0 0.00 0 0.0								
00 Physician Assistant 0.00 0 2,100 0 0 2.0 0 00 Nurse Practitioner 4.50 33,531 2,100 9,450 3.0 3.0 00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.0 0.00 Clinical Psychologist 0.00 0 0 0 6.00 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0.00 0.00 0 0.00				1	1	-		
DO Nurse Practitioner 4.50 33,531 2,100 9,450 3.0 0.00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.0 0.00 Clinical Psychologist 0.00 0 0 0 6.00 0 0 0 6.00 0 0 0 6.00 0 0 0 6.00 0								1.00
00 Subtotal (sum of lines 1 through 3) 6.36 43,175 17,262 43,175 4.0 0.00 Visiting Nurse 0.00 0 0 0 5.0 0.00 Clinical Psychologist 0.00 0 0 0 6.0 0.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7.0 0.01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7.0 0.02 Diabetes Self Management Training (FQHC 0.00 0 0 7.0 0.01 Total FTEs and Visits (sum of lines 4 6.36 43,175 43,175 43,175 0.00 Physician Services Under Agreements 0 0 0 9.0 9.0 0.00 Physician Services (Inder Agreements 0 0 9.0 9.0 9.0 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 13,700 11.0 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 13,700 11.0 2.614,585 14.025,767 10.0 1.00 Total nonreimbursable								2.00
00 Visiting Nurse 0.00 0 0 0 5.00 00 Clinical Psychologist 0.00 0 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 6.00 0 0 6.00 0 0 6.00 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 0 0 7.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3.0</td>								3.0
0.00 Clinical Psychologist 0.00 0 0 0.00 <						17, 262	43, 175	
C.00Clinical Social Worker0.000007.0.01Medical Nutrition Therapist (FQHC only)0.0000007.0.02Diabetes Self Management Training (FQHC0.000007.0only).00Total FTEs and Visits (sum of lines 46.3643,17543,1758.0.00Physician Services Under Agreements009.0.00Total FTEs and Visits (sum of Lines 46.3643,17500.00Physician Services Under Agreements009.0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,76710.01.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,70013,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,46712.03.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)0,99660613.04.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)2,614,58514.05.00Parent provider overhead allocated to facility (see instructions)4,404,85815.06.00Total overhead (sum of lines 14 and 15)7,019,44318.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 167,019,44318.0							°,	5.0
Nedical Nutrition Therapist (FQHC only)0.0000Diabetes Self Management Training (FQHC only)0.00000.01 y)Total FTEs and Visits (sum of lines 46.3643,17543,1750.00 Total FTEs and Visits (sum of lines 46.3643,17509.000.00 Physician Services Under Agreements009.000.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,76710.001.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,70011.002.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,46712.003.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)0.99660613.004.00 Total nosreim provider overhead allocated to facility (see instructions)4,404,85815.005.00 Parent provider overhead (sum of lines 14 and 15)7,019,44318.007.00 Allowable GME overhead (see instructions)0008.00 Enter the amount from line 167,019,44318.00							0	6.0
Diabetes Self Management Training (FOHC only)0.00 00001.00Total FTEs and Visits (sum of lines 4 through 7)6.3643,17543,17543,1758.02.00Physician Services Under Agreements00000002.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES000000.00Total costs of health care services (from Wkst. M-1, col. 7, line 28)4,022,76710.010.02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,46712.00.99660613.03.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)0.99660613.00.99660613.00.99660613.05.00Parent provider overhead allocated to facility (see instructions)4,404,85815.007,019,44316.0017.08.00Enter the amount from line 167,019,44318.0017.0017.0							0	7.0
onl y) Total FTEs and Visits (sum of lines 4 through 7)6.36 43,17543,17543,1758.0 8.00Physician Services Under Agreements009.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES1.000Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,7671.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,4673.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)0.9966064.00Total nongital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)2,614,5855.00Parent provider overhead allocated to facility (see instructions)4,404,8816.00Total overhead (sum of lines 14 and 15)7,019,4437.00Allowable GME overhead (see instructions)08.00Enter the amount from line 167,019,443							0	7.0
t. 00Total FTEs and Visits (sum of lines 4 through 7) Physician Services Under Agreements6.36 6.3643,175 943,1758.0 90009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.00009.000010.00010.010.01.00010.010.01.00010.010.01.00010.010.01.00010.010.01.00010.010.02.00010.010.02.00010.010.02.00010.010.03.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.9966064.0010.010.010.010.05.00Parent provider overhead (sum of lines 14 and 15)7,019,443 <td< td=""><td>. 02</td><td></td><td>0.00</td><td>0</td><td></td><td></td><td>0</td><td>7.0</td></td<>	. 02		0.00	0			0	7.0
through 7) Physician Services Under Agreements009.00Detremination of ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES1.00Detremination of the costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,7671.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,4673.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)0.9966064.00Total noneimbursable costs (from Wrsheet. M-1, col. 7, line 31)2,614,5855.00Parent provider overhead allocated to facility (see instructions)4,404,8586.00Total overhead (sum of lines 14 and 15)7,019,4437.00Allowable GME overhead (see instructions)08.00Enter the amount from line 167,019,443								
Description Physician Services Under Agreements 0 0 0 9.0 Image: Colspan="2">Image: Colspan="2">O 0 0 9.0 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 0 0 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 4,022,767 10.0 1.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 4,036,467 12.0 3.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0.996606 13.0 3.00 Agrent provider overhead allocated to facility (see instructions) 4,404,858 15.00 5.00 Total overhead (sum of lines 14 and 15) 7.00 Allowable GME overhead (see instructions) 4,404,858 15.00 6.00 Total overhead (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00		6.36	43, 175			43, 175	8.0
1.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,7671.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,4673.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)0.9966064.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)2,614,5855.00Parent provider overhead allocated to facility (see instructions)4,04,8586.00Total overhead (sum of lines 14 and 15)7,019,4437.00Allowable GME overhead (see instructions)08.00Enter the amount from line 167,019,443								
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,7671.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,4673.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)0.9966064.00Total nonreimbursable coverhead - (from Worksheet. M-1, col. 7, line 31)2,614,5855.00Parent provider overhead allocated to facility (see instructions)4,404,8816.00Total overhead (sum of lines 14 and 15)7,019,4437.00Allowable GME overhead (see instructions)0,17.008.00Enter the amount from line 167,019,443	9.00	Physician Services Under Agreements		0			0	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)4,022,7671.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)13,7002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)4,036,4673.00Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)0.9966064.00Total nonreimbursable coverhead - (from Worksheet. M-1, col. 7, line 31)2,614,5855.00Parent provider overhead allocated to facility (see instructions)4,404,8816.00Total overhead (sum of lines 14 and 15)7,019,4437.00Allowable GME overhead (see instructions)0,17.008.00Enter the amount from line 167,019,443							1 00	
1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 13,700 11.00 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 4,036,467 12.00 3.00 Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12) 0.996606 13.00 4.00 Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 2,614,585 14.00 5.00 Parent provider overhead allocated to facility (see instructions) 4,404,858 15.00 6.00 Total overhead (sum of lines 14 and 15) 7,019,443 16.00 7.00 Allowable GME overhead (see instructions) 0 0 0 8.00 Enter the amount from line 16 7,019,443 18.00		DETERMINATION OF ALLOWABLE COST APPLICABLE 1	TO HOSPI TAL-BASE	ED RHC/FQHC SE	RVI CES			
1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 13,700 11.00 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 4,036,467 12.00 3.00 Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12) 0.996606 13.00 4.00 Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 2,614,585 14.00 5.00 Parent provider overhead allocated to facility (see instructions) 4,404,858 15.00 6.00 Total overhead (sum of lines 14 and 15) 7,019,443 16.00 7.00 Allowable GME overhead (see instructions) 0 0 0 8.00 Enter the amount from line 16 7,019,443 18.00	0.00	Total costs of health care services (from W	kst. M-1, col.	7, line 22)			4, 022, 767	10.00
3.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)0.99660613.04.00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)2,614,58514.05.00Parent provider overhead allocated to facility (see instructions)4,404,85815.06.00Total overhead (sum of lines 14 and 15)7,019,44316.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 167,019,44318.0	1.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			13, 700	11.0
4.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 2,614,585 14.0 5.00 Parent provider overhead allocated to facility (see instructions) 4,404,858 15.0 6.00 Total overhead (sum of lines 14 and 15) 7,019,443 16.0 7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 7,019,443 18.0	2.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			4, 036, 467	12.0
5.00Parent provider overhead allocated to facility (see instructions)4,404,85815.06.00Total overhead (sum of lines 14 and 15)7,019,44316.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 167,019,44318.0	3.00	Ratio of hospital -based RHC/FQHC services (ine 10 divided	by line 12)			0. 996606	13.0
5.00Parent provider overhead allocated to facility (see instructions)4,404,85815.06.00Total overhead (sum of lines 14 and 15)7,019,44316.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 167,019,44318.0	4.00	Total hospital-based RHC/FQHC overhead - (fi	rom Worksheet. I	M-1, col. 7, I	ine 31)		2, 614, 585	14.0
7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 7,019,443 18.0	5.00				-		4, 404, 858	15.0
7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 7,019,443 18.0	6.00			-			7, 019, 443	16.0
8.00 Enter the amount from line 16 7,019,443 18.0	7.00						0	17.0
9.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 6,995,619 19.0	8.00						7, 019, 443	18.0
	19.00	Overhead applicable to hospital-based RHC/FG	QHC services (li	ine 13 x line	18)		6, 995, 619	19.00

 19.00
 Overhead applicable to hospital-based RhC/Func services (time is x time is)
 0, 753, 017
 17.00

 20.00
 Total allowable cost of hospital-based RHC/FUNC services (sum of lines 10 and 19)
 11, 018, 386
 20.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	PITAL, INC. Provider CCN: 15-1310	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES		From 01/01/2022		
	Component CCN: 15-8541	To 12/31/2022	Date/Time Pre	
	Title XVIII	RHC II	5/26/2023 3:0	9 pili
		-	1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		4, 218, 440	1.0
.00 Cost of injections/infusions and their administration (from W	· · · · ·		310, 979	2.0
.00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		3, 907, 461	3. (
.00 Total Visits (from Wkst. M-2, column 5, line 8)			12, 573	4.(
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		10 570	5.0
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			12, 573 310. 78	6. (7. (
		Cal cul ati on		7.0
			Rate Period 1	
		N/A	(01/01/2022	
			through	
		1.00	12/31/2022)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	0.00	2.00	8.0
.00 Rate for Program covered visits (see instructions)		0.00	244.94	9.0
CALCULATION OF SETTLEMENT		0100	211171	
0.00 Program covered visits excluding mental health services (from	contractor records)	0	2, 170	10.
1.00 Program cost excluding costs for mental health services (line	services (line 9 x line 10) 0			
2.00 Program covered visits for mental health services (from contra	actor records)	0	0	12.
3.00 Program covered cost from mental health services (line 9 x li		0	0	13.
4.00 Limit adjustment for mental health services (see instructions		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction			504 500	15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	531, 520	
6.01 Total program charges (see instructions)(from contractor's re 6.02 Total program preventive charges (see instructions)(from prov			540, 670 47, 137	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	-		46, 340	
6.04 Total Program non-preventive costs ((line 16.02) The 18.07) times			347, 565	
(Titles V and XIX see instructions.)			017,000	
6.05 Total program cost (see instructions)		0	393, 905	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		50, 724	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		88, 531	19. (
records) 0.00 Net Medicare cost excluding vaccines (see instructions)			393, 905	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		52,079	
2.00 Total reimbursable Program cost (line 20 plus line 21)			445, 984	
3.00 Allowable bad debts (see instructions)			0	23.
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			445, 984	
6.01 Sequestration adjustment (see instructions)			5, 619	
6.02 Demonstration payment adjustment amount after sequestration			0 202 125	26.
7.00 Interim payments 8.00 Tentative settlement (for contractor use only)			382, 135 0	27. 28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.1	02 27 and 28)		58, 230	
0.00 Protested amounts (nonallowable cost report items) in accorda	· · · ·		0	
		·	Ũ	

ealth Financial Systems PARKVIEW WABASH HOS ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	PITAL, INC. Provider CCN: 15-1310	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVICES		From 01/01/2022		
	Component CCN: 15-8542	To 12/31/2022	Date/Time Pre	
	Title XVIII	RHC III	5/26/2023 3:0	9 pili
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from			11, 018, 386	
.00 Cost of injections/infusions and their administration (from W			844, 715	2.0
.00 Total allowable cost excluding injections/infusions (line 1 mi	inus line 2)		10, 173, 671	3.0
.00 Total Visits (from Wkst. M-2, column 5, line 8) .00 Physicians visits under agreement (from Wkst. M-2, column 5, l			43, 175 0	4. 5.
.00 Physicians visits under agreement (from Wkst. M-2, column 5, l .00 Total adjusted visits (line 4 plus line 5)	TTTTE 9)		43, 175	
.00 Adjusted cost per visit (line 3 divided by line 6)			235.64	7.
		Cal cul ati on		7.
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
		1.00	12/31/2022)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	<u>2.00</u> 213.28	8.
00 Rate for Program covered visits (see instructions)		0.00	213.28	
CALCULATION OF SETTLEMENT		0.00	210120	
0.00 Program covered visits excluding mental health services (from	contractor records)	0	4, 491	10.
1.00 Program cost excluding costs for mental health services (line		0	957, 840	11.
2.00 Program covered visits for mental health services (from contra	,	0	0	
3.00 Program covered cost from mental health services (line 9 x line)	·	0	0	13.
4.00 Limit adjustment for mental health services (see instructions)		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	·	0	957, 840	15. 16.
6.01 Total program charges (see instructions)(from contractor's rea		0	1, 023, 128	
6.02 Total program preventive charges (see instructions)(from provi			84, 344	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	-		78, 961	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.03			609, 718	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	688, 679	
7.00 Primary payer amounts	(6		0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		116, 732	18.
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		164, 412	19.
records)			101, 112	' '.
0.00 Net Medicare cost excluding vaccines (see instructions)			688, 679	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		117, 310	21.
2.00 Total reimbursable Program cost (line 20 plus line 21)			805, 989	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)			0	
 4.00 Allowable bad debts for dual eligible beneficiaries (see insti 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 	ructions)		0	24. 25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
5.99 Demonstration payment adjustment amount before sequestration	-,		0	
6.00 Net reimbursable amount (see instructions)			805, 989	
6.01 Sequestration adjustment (see instructions)			10, 155	
6.02 Demonstration payment adjustment amount after sequestration			0	26.
7.00 Interim payments			671, 096	
8.00 Tentative settlement (for contractor use only)	00 07 L CC		0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda	· · · ·		124, 738	
			0	30.

Health Financial	Systems PARKVIEW WABASH OSPITAL-BASED RHC/FQHC VACCINE COST	Provider C	N. 15_1310	Period:	u of Form CMS-2 Worksheet M-4	2552-10
	USITIAL-DASED KHOTI DIG VACCINE CUST			From 01/01/2022		
		Component (CCN: 15-8541	To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
			XVIII	RHCII		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
		1.00	0.00	0.01	PRODUCTS	
1 00 Ulastata		1.00	2.00	2.01	2.02	1.00
	re staff cost (from Wkst. M-1, col. 7, line 10) njection/infusion staff time to total health	1, 564, 255 0. 001410				1.00 2.00
	(infusion health care staff cost (line 1 x line	2, 206	4, 1	61 30	0	3.00
(from you	s/infusions and related medical supplies costs ⁻ records)	88, 733				4.00
6.00 Total dire	st of injections/infusions (line 3 plus line 4) ect cost of the hospital-based RHC/FQHC (from M-1, col. 7, line 22)	90, 939 1, 803, 253	38, 5 1, 803, 2			5.00 6.00
7.00 Total over 8.00 Ratio of i	<pre>rhead (from Wkst. M-2, line 19) njection/infusion direct cost to total direct</pre>	2, 415, 187 0. 050431	2, 415, 1 0. 0213			7.00 8.00
9.00 Overhead o 10.00 Total inje	e 5 divided by line 6) cost - injection/infusion (line 7 x line 8) ection/infusion costs and their administration of lines 5 and 9)	121, 800 212, 739			0 0	9.00 10.00
11.00 Total numl 12.00 Cost per i 13.00 Number of	per of injections/infusions (from your records) njection/infusion (line 10/line 11) injection/infusion administered to Program	450 472. 75 74	106.	49 6 18 1, 348. 50 61 0		11.00 12.00 13.00
	ries COVID-19 vaccine injections/infusions red to MA enrollees			0	0	13.01
admi ni stra	ost of injections/infusions and their ation costs (line 12 times the sum of lines 13 as applicable)	34, 984	17, 0	95 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1.00	2.00	
	t of injections/infusions and their administratio and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		310, 979	15.00
16.00 Total Prog	gram cost of injections/infusions and their admin 2, 2.01, and 2.02, line 14) (transfer this amou	istration costs			52, 079	16. OC

ealth Financial Systems PARKVIEW WABASH OMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	HOSPITAL, INC. Provider C	CN: 15-1310	Peri od:	u of Form CMS-2 Worksheet M-4	
	Component (CCN: 15-8542	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 3:0	
	Title	XVIII	RHC III		
	PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
	1.00	2.00	2. 01	2.02	
 Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time 	3, 415, 961 0. 001907	3, 415, 9 0. 0027		3, 415, 961 0. 000000	1.00 2.00
.00 Injection/infusion health care staff cost (line 1 x line 2)	6, 514	9, 5	41 0	0	3.0
.00 Injections/infusions and related medical supplies costs (from your records)	229, 241	63, 1	07 0	0	4.0
 Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 	235, 755 4, 022, 767	72, 6 4, 022, 7		0 4, 022, 767	5.0 6.0
 Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) 	6, 995, 619 0. 058605	6, 995, 6 0. 0180			7.0 8.0
.00 Overhead cost - injection/infusion (line 7 x line 8) D.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	409, 978 645, 733			0 0	
 Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program beneficiaries 	1, 152 560. 53 143	117.			11. 0 12. 0 13. 0
3.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	80, 156	37, 1	54 0	0	14.0
				COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
			1.00	2.00	
5.00 Total cost of injections/infusions and their administratic 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		844, 715	15.0
6.00 Total Program cost of injections/infusions and their admir	nistration costs	s (sum of 3, line 21)		117, 310	16. (

Health Financial Systems PARKVIEW WABASH	HOSPITAL, INC.	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1310	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8541	From 01/01/2022 To 12/31/2022	Date/Time Pre	
		RHC II	5/26/2023 3:0	9 pm
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	382, 135	1.00
2.00 Interim payments payable on individual bills, either subm	itted or to be submitted to		0	2.00
the contractor for services rendered in the cost reporting			0	2.00
"NONE" or enter a zero	g per loa. It none, wit te			
3.00 List separately each retroactive lump sum adjustment amou	nt based on subsequent			3.00
revision of the interim rate for the cost reporting perior				0.00
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3. 01			0	3.01
3. 02			0	3.02
3. 03			0	3.03
3. 04			0	3.04
3. 05			0	3.05
Provider to Program			0	5.05
3. 50			0	3.50
3.51			0	3.50
3. 52			0	3.51
3. 53			0	3.53
3.54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-	3 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trai			382, 135	4.00
27)	ister to worksheet w 5, 111		302, 133	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after d	esk review. Also show date	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				0.00
Program to Provider				
5. 01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-	5. 98)		0	5.99
6.00 Determined net settlement amount (balance due) based on t				6.00
6.01 SETTLEMENT TO PROVIDER			58, 230	6.01
6.02 SETTLEMENT TO PROGRAM		1	0	6.02
7.00 Total Medicare program liability (see instructions)			440, 365	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor				8.00

leal th	n Financial Systems PARKVIEW WABA	SH HOSPITAL, INC.	In Lie	eu of Form CMS-2	2552-1
	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1310	Peri od:	Worksheet M-5	
ERVI	CES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8542	From 01/01/2022 To 12/31/2022		
			RHC III	0/20/2020 0.0	<i>y</i> pm
				rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			671, 096	1.0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to			0	2.0
	the contractor for services rendered in the cost reporting period. If none, write				
~ ~	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amo				3.0
	revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3. (
02				0	3.
02				0	3.
04				0	3.
05				0	3.
	Provider to Program			-	
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (th	ransfer to Worksheet M-3, li	ne	671, 096	4.
~~	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.
	Program to Provider)			
01				0	5.
02				0	5.
03				0	5.
00	Provider to Program				0.
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER			124, 738	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			795, 834	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	