payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

EXPLES 05-31-2019

					5/30/2018 /:	.46 am
PART I - COST	REPORT STATUS					
Provi der use only	1. [X] Electronically filed 2. [] Manually submitted co			Date: 5/30/201	3 Time:	7:46 a
,	3. [0] If this is an amended 4. [F] Medicare Utilization.	d report enter the number o		resubmitted this cos	st report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended		this Provider CCN 12.	NPR Date: Contractor's Vendor [O]If line 5, col number of time	umn 1 is 4:	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Ti ti s	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	97, 043	-726, 108	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	4, 818	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	101, 861	-726, 108	0	0	200. 00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 9:58 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 710 NORTH EAST STREET P0 Box: 548 1.00 1.00 Zip Code: 46992-0548 County: WABASH 2.00 City: WABASH State: IN 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N) Туре Certi fi ed Number Number XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PARKVI EW WABASH 151310 99915 12/17/2001 N 0 3.00 HOSPITAL, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF PARKVIEW WARASH 157310 99915 N 12/17/2001 N 0 7 00 7.00 HOSPITAL SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA WABASH-MIAMI HOME 157061 99915 01/01/1979 Ν Ρ Ν 12.00 HEALTH 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce WARASH-MLAML HOSPLCE 151545 99915 01/01/1996 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2 or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 2 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" "N" for no for ves or Other In-State In-State Out-of Out-of Medicai d Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3. 00 4. 00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24 00 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. 25.00 If this provider is an IRF, enter the in-state o 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

	Financial Systems PARKVIEW W LL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provi der CC	CN: 15-1310	Peri od: From 01/01 To 12/31	/2017 /2017	5/29/20	me Pre	parec 8 am
					Urban/Ru				-
00	Enter your standard geographic classification (not wa	ne) sta	atus at the bed	ainnina of th	1. 00	, 2	2.0	JU	26. (
. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta	atus at the end	d of the cost		2	2		27. (
. 00	enter the effective date of the geographic reclassifing this is a sole community hospital (SCH), enter the	cati on	in column 2.			C)		35. (
	effect in the cost reporting period.				Begi nni	ng:	Endi	ng:	
00	Enter applicable beginning and ending dates of SCH st	a+ua (Cuboonint lino	2/ for number	1.00)	2. (00	36.
ŀ	of periods in excess of one and enter subsequent date	S.							
. 00	If this is a Medicare dependent hospital (MDH), enter sin effect in the cost reporting period.	the nu	umber of period	ds MDH status	5	C			37.
	s this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37.
. 00	nstructions) 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.
·	sitter Saperagaent dates.				Y/N		Y/		
. 00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment i	for low volum	1.00 ne N)	2. (39.
	nospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column nstructions)	or (ii eage re)? Enter in co equirements in	olumn 1 "Y" accordance					07.
. 00	s 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. E	Enter "Y" for y				N		40.
	-					V 1. 00	XVIII 0 2.00	XI X 3. 00	-
	Prospective Payment System (PPS)-Capital					1.00	0 2.00	3.00	
ŀ	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N N	N	N N	45. 46.
	oursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c	. L, P1	t. III and Wks	t. L-1, Pt. I	through	N	N	N	47.
00	s the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for r	10.	N	N	N	48.
ŀ	s this a hospital involved in training residents in or "N" for no.	•	. 0		,	N			56.
	If line 56 is yes, is this the first cost reporting pGME programs trained at this facility? Enter "Y" for s "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y'N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	r "N" for no in nis cost report plete Worksheet	n column 1. I ting period?	f column 1 Enter "Y"				57
	fline 56 is yes, did this facility elect cost reimb	ursemer	nt for physicia	ans' services	s as				58
- 1	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59
				NAHE 413.8 Y/N	5 Workshe Li ne		Pass-TI Qual i fi Cri teri d	cation	
		****		1. 00	2.00)	3. (00	
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (costs for structions)	N					60
	, , , , , , , , , , , , , , , , , , ,	Y/N	IME	Direct GME	IME		Di rec	t GME	
		1. 00	2. 00	3. 00	4.00)	5. 0	00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		2.00		0. 00		0.00	61
01	Enter the average number of unweighted primary care Enter the average number of unweighted primary care Enter from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see nstructions)								61
02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)								61
	and/or general surgery residents, which is used for								61

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	X IDENTIFICATION DA	TA	Provi der CO		Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/29/2018 9:58	pared:
		Y/N	IME	Direct GME	IME	Direct GME	U UIII
		1. 00	2. 00	3. 00	4. 00	5. 00	
 1.04 Enter the number of unweighted pri surgery allopathic and/or osteopat current cost reporting period (see Enter the difference between the b and/or general surgery FTEs and th primary care and/or general surger 61.04 minus line 61.03). (see inst 	hic FTEs in the instructions). aseline primary e current year's y FTE counts (line ructions)						61. (
1.06 Enter the amount of ACA §5503 awar used for cap relief and/or FTEs th care or general surgery. (see inst	at are nonprimary						61. (
pare or general eargery. (eee rise	. 401. 61.6)	Prog	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2. 00	3.00	4.00	
specialty, if any, and the number for each new program. (see instruction column 1, the program name. Enter program code. Enter in column 3, the unweighted count. Enter in column FTE unweighted count. 1. 20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded program.	tions) Enter in in column 2, the he IME FTE 4, the direct GME each expanded number of FTE				0. 00	0. 00	61. 2
instructions) Enter in column 1, t Enter in column 2, the program cod 3, the IME FTE unweighted count. E the direct GME FTE unweighted coun	e. Enter in column nter in column 4,					1.00	
ACA Provisions Affecting the Healt					-1 -1 6	0.00	(2)
2.00 Enter the number of FTE residents your hospital received HRSA PCRE f 2.01 Enter the number of FTE residents	unding (see instruc	tions)					62. (62. (
during in this cost reporting peri Teaching Hospitals that Claim Resi				ns)			
Has your facility trained resident "Y" for yes or "N" for no in colum	s in nonprovider se	ttings o	during this co			N	63. (
				Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
	FTF D			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after Jul 1.00 Enter in column 1, if line 63 is y in the base year period, the numbe resident FTEs attributable to rota settings. Enter in column 2 the n resident FTEs that trained in your of (column 1 divided by (column 1	y 1, 2009 and befor es, or your facilit r of unweighted non tions occurring in umber of unweighted hospital. Enter in	re June (ry traine a-primary all nonp l non-pri a column	ad residents and residents are care corovider are at the ratio	This base yea			64. (
jor (corumn r drvrded by (corumn r	Program Name		gram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/	

1.00

Unwei ghted FTEs Nonprovi der Si te

3. 00

2.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

Unwei ghted FTEs in Hospital

4. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 9:58 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Heal th	Financial Systems PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS	5-2552-10
	L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1310	Peri od:	Worksheet S-	
			From 01/01/2017 To 12/31/2017	Part I Date/Time Pr	enared:
			10 12/31/2017	5/29/2018 9:	58 am
				1.00	_
	Long Term Care Hospital PPS			11.00	
	s this a long term care hospital (LTCH)? Enter "Y" for yes a s this a LTCH co-located within another hospital for part or 'Y" for yes and "N" for no.		ng period? Enter	N N	80. 00 81. 00
	TEFRA Providers			1	
	s this a new hospital under 42 CFR Section §413.40(f)(1)(i) T Did this facility establish a new Other subprovider (excluded			N	85. 00 86. 00
07.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				07.00
87.00	s this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under section	1	N	87. 00
	rood(d)(1)(b)(vr): Enter 1 Tor yes or N Tor no.		V	XIX	
			1. 00	2.00	
	Title V and XIX Services				
90. 00	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? Enter "Y" for	N	Y	90.00
91. 00	s this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applic		N	N	91. 00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual	certification)? (see		N	92. 00
93. 00	nstructions) Enter "Y" for yes or "N" for no in the applicabl Does this facility operate an ICF/IID facility for purposes of		N	N	93. 00
94. 00	'Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, an	d "N" for no in the	N	N	94. 00
05.00	applicable column.			0.00	05.00
	If line 94 is "Y", enter the reduction percentage in the appli Does title V or XIX reduce operating cost? Enter "Y" for yes o		0. 00 N	0. 00 N	95. 00 96. 00
97. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the appli	cable column.	0. 00	0.00	97. 00
	Ooes title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	rns and residents post	Y	Y	98. 00
98 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the repo	rting of charges on Wks	:. Y	Υ	98. 01
70. 01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl			1	70.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calc	ulation of observation	Υ	Υ	98. 02
	ped costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.	"N" for no in column 1			
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critic			N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	or "N" for no in column	1		
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH re		N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in c n column 2 for title XIX.	olumn 1 for title V, and	1		
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back			Y	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.	umn 1 for title V, and i	n		
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column 1		Y	Y	98. 06
	column 2 for title XIX.	·			
	Rural Providers			1	
	Does this hospital qualify as a CAH?	aluatua matkad af a	Y N		105. 00
106.00	If this facility qualifies as a CAH, has it elected the all-in for outpatient services? (see instructions)	ciusive method of paymei	nt N		106. 00
107.00	f this facility qualifies as a CAH, is it eligible for cost r		N		107. 00
	training programs? Enter "Y" for yes or "N" for no in column 1		.+		
	yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II.	and the program is cos	, ,		

reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2.00	3.00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					

	1. 00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110.00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-1310	Peri od:		Worksheet S-	2
THE WIND HOST THE TEXT OF STATE OF STAT		From 01/01	/2017 /2017	Part I Date/Time Pr 5/29/2018 9:	epared
		1. 00	<u> </u>	2.00	4
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional befor tele-health services.	ng period? Ente Y, enter the in column 2.	N	J	2.00	111. (
			1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for long psychiatric, rehabilitation and long term hospitals providers) based or Pub. 15-1, chapter 22, §2208. 1.	2 is "E", ente term care (inc n the definitio	rin column Ludes	N	0	115. (
16.00 Is this facility classified as a referral center? Enter "Y" for yes or 17.00 Is this facility legally-required to carry malpractice insurance? Enter no.	r "Y" for yes o		N N		116. 0
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter claim-made. Enter 2 if the policy is occurrence.	1 if the polic	y is	0		118. 0
jordim made. Error Error porto, to decarronce.	Premi ums	Losse	es	Insurance	
	1. 00	2. 0	0	3. 00	
18.01 List amounts of malpractice premiums and paid losses:	328,	522	0	21, 40	118. 0
		1. 00)	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center other. Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 19.00 DO NOT USE THIS LINE		N			118.
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless; \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see in Enter in column 2, "Y" for yes or "N" for no.	"Y" for yes or r the Outpatien			N	120.
21.00 Did this facility incur and report costs for high cost implantable devi	ces charged to	Y			121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §10 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", end the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and '	'N" for no lf	l N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the cen					126.
in column 1 and termination date, if applicable, in column 2. 27.00 f this is a Medicare certified heart transplant center, enter the cer	tification date				127.
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the cer	tification date				128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certicolumn 1 and termination date, if applicable, in column 2.	fication date	in			129.
30.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.	certi fi cati on				130.
B1.00 of this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.	e certification				131.
32.00 If this is a Medicare certified islet transplant center, enter the cerin column 1 and termination date, if applicable, in column 2.	tification date				132.
33.00 If this is a Medicare certified other transplant center, enter the cerin column 1 and termination date, if applicable, in column 2.	tification date				133.
34.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	er in column 1				134.
All Providers 40.00 Are there any related organization or home office costs as defined in (CMS Pub 15-1	У			140.
40. DOJALE THELE ALLY LELATED OLYAHIZATION OF HOME OFFICE COSTS AS DEFINED IN C					

From 01/01/2017 Part I Date/Time Prepared: To 12/31/2017 5/29/2018 9:58 am 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 SERVI CE 142.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 142.00 143.00 City: FORT WAYNE State: ΙN Zip Code: 46845 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title XIX Title V 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF Ν Ν Ν N 157 00 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code Name County **CBSA** State | 0 1.00 2 00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 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 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 167.00 199, 434 168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2016 09/30/2017 170 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities	1.6			1	
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	ir yes, is tr	ie provider is	N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. N					7. 00
8. 00	Were nursing school and/or allied health programs approved and/or renewed during the					8.00
6.00	cost reporting period? If yes, see instructions.	and/or renewed	r durring the	IN		0.00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9.00
7.00	program in the current cost report? If yes, see instruction		a. caacat.c			7.00
10.00	Was an approved Intern and Resident GME program initiated of		he current	N		10.00
	cost reporting period? If yes, see instructions.					
11.00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1. 00	
	Bad Debts					
12.00					Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection p	oolicy change o	luring this cost	reporting	Y	13. 00
14 00	period? If yes, submit copy.		·		N	14. 00
14. 00						
15 00	Bed Complement	ng poriod? If	voc coo instri	ictions	l N	15. 00
13.00	5.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N Part A Part B					
		Y/N	Date	Y/N	Date	
		1, 00	2.00	3. 00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	05/01/2018	Υ	05/01/2018	16. 00
	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)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
16.00	Report data for additional claims that have been billed	IN IN		IN		10.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00		l N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					
	•		· ·			

Heal th Fi	inancial Systems PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	-2552-10	
HOSPI TAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	Provi der CCN: 15-1310 Peri od: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Pro 5/29/2018 9:	epared:	
		Descri		Y/N	Y/N		
20. 00 1	fline 16 or 17 is yes, were adjustments made to PS&R	()	1. 00 N	3. 00 N	20.00	
	eport data for Other? Describe the other adjustments:			IN	IV.	20.00	
		Y/N	Date	Y/N	Date		
21. 00 Wa	as the cost report prepared only using the provider's	1.00 N	2. 00	3. 00 N	4. 00	21. 00	
	ecords? If yes, see instructions.	14		14		21.00	
					1. 00		
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)				
	apital Related Cost ave assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00	
23. 00 Ha	ave changes occurred in the Medicare depreciation expense eporting period? If yes, see instructions.		als made duri	ng the cost	N	23. 00	
24. 00 W	ere new leases and/or amendments to existing leases entere f yes, see instructions	ed into during	this cost rep	oorting period?	N	24. 00	
25. 00 Ha	ave there been new capitalized leases entered into during nstructions.	the cost repor	ting period?	If yes, see	N	25. 00	
i i	ere assets subject to Sec. 2314 of DEFRA acquired during th nstructions.	•	0 .		N	26. 00	
C	as the provider's capitalization policy changed during the opy.	e cost reportin	g period? If	yes, submit	N	27. 00	
28. 00 W							
29. 00 Di	eriod? If yes, see instructions. id the provider have a funded depreciation account and/or reated as a funded depreciation account? If yes, see instr		bt Service Re	eserve Fund)	N	29. 00	
30. 00 Ha	as existing debt been replaced prior to its scheduled matu nstructions.		debt? If yes,	see	N	30. 00	
31. 00 Ha	as debt been recalled before scheduled maturity without is nstructions.	ssuance of new	debt? If yes,	see	N	31. 00	
	urchased Services ave changes or new agreements occurred in patient care ser	rvices furnishe	d through cor	ntractual	N	32. 00	
33. 00 I	rrangements with suppliers of services? If yes, see instru fline 32 is yes, were the requirements of Sec. 2135.2 app	uctions. Dlied pertainin	g to competit	ive bidding? If	N	33. 00	
Pr	o, see instructions. rovider-Based Physicians					-	
1.	re services furnished at the provider facility under an ar f yes, see instructions.	Ü	•	. ,	Y	34.00	
	f line 34 is yes, were there new agreements or amended exi hysicians during the cost reporting period? If yes, see ir		ts with the p		Y	35. 00	
				Y/N 1. 00	2. 00		
Нс	ome Office Costs			1.00	2.00		
36. 00 We	ere home office costs claimed on the cost report?			Y		36. 00	
	f line 36 is yes, has a home office cost statement been pr f yes, see instructions.	repared by the	home office?	Y		37. 00	
tl	f line 36 is yes , was the fiscal year end of the home off he provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.	N		38. 00	
S	f line 36 is yes, did the provider render services to othe ee instructions.	,	,			39. 00	
						40. 00	
	1.00 2.00						
	Cost Report Preparer Contact Information						
h	eld by the cost report preparer in columns 1, 2, and 3,	ERIC		NI CKESON		41. 00	
42. 00 Ei	espectively. nter the employer/company name of the cost report reparer.	PARKVIEW HEALT	H SYSTEM, INC			42. 00	
43. 00 E		2603738406		ERI C. NI CKESON@I	PARKVI EW. COM	43. 00	

Heal th	Financial Systems PARKVIEW WABASH	HOSPITAL, INC.	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Peri od: From 01/01/2017	Worksheet S-2 Part II			
			To 12/31/2017		pared: 8 am		
		3. 00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DIRECTOR, REIMBURSEMENT			41. 00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report				42. 00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						
42. 00	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	DIRECTOR, REIMBURSEMENT			42. 00		

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:
 Heal th Financial
 Systems
 PARKVIEW WABASH HOSPITAL, INC.

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

						To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
							I/P Days / O/P	<u> </u>
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	5 44, 880. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2.00	HMO and other (see instructions)							2. 00 3. 00
3. 00 4. 00	HMO I PF Subprovi der							4. 00
5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed SNI							6.00
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	5 44, 880. 00		7. 00
7.00	beds) (see instructions)			23	7, 12	44, 000. 00	ή	7.00
8.00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			25	9, 12	5 44, 880. 00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		0		0		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	00.00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		٥٦			0	
27. 00	Total (sum of lines 14-26)			25			0	27. 00
28. 00 29. 00	Observation Bed Days						0	28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)			0		0		32.00
32. 00	Total ancillary labor & delivery room			U	1			32. 00
JZ. UI	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
		'	•		•	•	•	•

 Heal th Financial
 Systems
 PARKVIEW V

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-1310

Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Ti me Prepared: 5/29/2018 9:58 am

					5/29/2018 9:58 am		
		I/P Days	s / O/P Visits	/ Trips	Full Time	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	860	28	1, 769			1. 00
2.00	HMO and other (see instructions)	560	54				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	l o	o				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	22	o	22			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	22	ő	79			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	882	28	1, 870			7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	0			13.00
14. 00	Total (see instructions)	882	28	1, 870	0.00	168. 60	•
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF						16, 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	ol	o	429	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE	ol	0	0	0.00	0.00	1
24. 10	HOSPICE (non-distinct part)	ol	o	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	l ol	o	0	0.00	0.00	1
27. 00	Total (sum of lines 14-26)				0.00		1
28. 00	Observation Bed Days		8	719			28. 00
29. 00	Ambul ance Trips	ol					29. 00
30. 00	Employee discount days (see instruction)	1		9			30.00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	ا	0	0			32. 00
32. 01	Total ancillary labor & delivery room	l	Ĭ	0			32. 01
02.01	outpatient days (see instructions)			O			52.01
33. 00	LTCH non-covered days	o					33. 00
	LTCH site neutral days and discharges	l o					33. 01
55.51	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	١	ı		I .	ı	, 55.57

In Lieu of Form CMS-2552-10
Worksheet S-3
01/2017 Part I
31/2017 Date/Time Prepared:
5/29/2018 9:58 am
 Heal th Financial
 Systems
 PARKVIEW WABASH HOSPITAL, INC.

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1310
 Peri od: From 01/01/2017 To 12/31/2017

		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	315	9	688	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			191	18		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	315	9	688	
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE	0.00					21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00 24. 00
24. 00 24. 10	HOSPICE	0.00					24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25		0. 00					26. 25
27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0.00					20. 23
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days (see firstruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00
32. UI	outpatient days (see instructions)						J2. U1
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			Ö			33. 01
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ı		1 9			

Heal th	Financial Systems PA	ARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
	BEALTH AGENCY STATISTICAL DATA				Period: From 01/01/2017	Worksheet S-4	
			Component		To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
-					Home Health	PPS	o un
					Agency I		
0.00	County				1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	0	1	0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	0.00		0.00 oloyees (Full Ti		2. 00
		Enter the number		Staff	Contract	Total	
		, , , , , , , , , , , , , , , , , , , ,					
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		0. 00				
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		0. 00 0. 00	
6.00	Direct Nursing Service			0.0	0.00	0. 00	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0		0. 00 0. 00	
9. 00	Physical Therapy Supervisor			0.0		0.00	1
10.00	Occupational Therapy Service			0.0		0.00	1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0		0. 00 0. 00	1
13. 00	Speech Pathology Supervisor			0.0		0.00	
14. 00 15. 00	Medical Social Service			0.0		0.00	1
16. 00	Medical Social Service Supervisor Home Health Aide			0.0		0. 00 0. 00	
17. 00	Home Health Aide Supervisor			0.0			1
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			99915			20. 00
	during this cost reporting period (line 20 contains the first code).						
		Full Ep Without	<u>isodes</u> With Outliers	LUPA Enisodes	s PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	96	1	1		121	21.00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	14, 308 157	173 18	1	8 1, 285 0 0	18, 474 175	
24.00	Physical Therapy Visit Charges	27, 870	3, 113		0 0	30, 983	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	30 4, 014	17 2, 370		1 0	48 6, 575	
27. 00	Speech Pathology Visits	4,014	2, 370		o o	0,373	27. 00
28. 00	1 33	0	0	1	0 0	0	1
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0 0	0	1	0 0	0	29. 00 30. 00
31. 00	Home Health Aide Visits	O	0		0 0	0	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	0 283	0 36	1	0	0 344	32. 00 33. 00
	29, and 31)		30				
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 46, 192	5, 656		0 9 1, 285	0 56, 032	34. 00 35. 00
	30, 32, and 34)		5, 000				
36. 00	Total Number of Episodes (standard/non outlier)	0			0	0	36. 00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	0	0		0 0	0	
55. 50	1.212. Hor. Hour to mour our ouppry onar ges	١	O	ı	-, 0		, 55. 56

Provider CCN: 15-1310	Heal th	Financial Systems	P.A	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
Unduplicated Days			I DATA				From 01/01/2017	PARTS I THROUGH IV	
Induplicated Days								5/29/2018 9:5	8 am
Days Title XVIII Title XIX Title XVIII Title XIX Nursing Facility Total (sum of cols. 1, 2 & 5)			Hardinal Landard				Hospi ce I		
Skilled Nursing Facility			Days		1				
Nursing Facility F			Title XVIII	Title XIX			All Other		
Note									
1.00 2.00 3.00 4.00 5.00 6.00						Facility		5)	
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 1.00			1, 00	2, 00		4.00	5. 00	6. 00	
2. 00 Hospice Routine Home Care 3. 00 Hospice Routine Home Care 3. 00 Hospice General Inpatient Respite Care 4. 00 4.		PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015	<u>'</u>		
3.00	1.00	Hospice Continuous Home Care							1.00
4.00	2.00								
5.00 Total Hospice Days Part III - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 6.00 Number of patients receiving hospice care 6.00 Number of unduplicated 7.00 Continuous Care hours billable to Medicare 8.00 Average Length of Stay (line 5 / line 6) 9.00 Unduplicated census count 9.00 Unduplicated census count 9.00 NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII Title XIX Other Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00									
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015 6.00 Number of patients receiving hospice care 7.00 Total number of unduplicated Continuous Care hours billable to Medicare 8.00 Average Length of Stay (line 5 / line 6) Unduplicated census count NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII Title XIX Other Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00 PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 10.00 Hospice Continuous Home Care 0 0 0 0 0 0 10.00 11.00 Hospice Routine Home Care 1, 301 14 0 1, 315 11.00 12.00 Hospice General Inpatient Respite Care 18 7 0 25 13.00 14.00 Hospice General Inpatient Care 18 7 0 25 13.00 14.00 Hospice Inpatient Respite Care 1, 324 21 0 1, 345 14.00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospice Inpatient Respite Care 0 0 0 0 15.00									
6.00 Number of patients receiving hospice care	5.00		DEDODTI NO DEDI	ODC DECLAIMING	DEFODE OCTOBER	1 2015			5.00
Note			REPORTING PERI	ODS BEGLINNING	BEFORE OCTOBER	T, 2015			/ 00
Total number of unduplicated Continuous Care hours billable to Medicare	6.00								6.00
Continuous Care hour's billable to Medicare	7 00								7 00
8.00 Average Length of Stay (line 5 9.00 Unduplicated census count 9.00 Unduplicated census count 9.00 NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII Title XIX Other Total (sum of cols. 1 through 3) 1.00 2.00 3.00 4.00	7.00								7.00
9.00		to Medicare							
9.00 Unduplicated census count 9.00	8.00								8. 00
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4. Title XVIII									
Title XVIII		<u> </u>							9. 00
Col s. 1 through 3	NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
Name					Title XVIII	Title XIX	Other	Total (sum of	
1.00 2.00 3.00 4.00									
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 10.00 10.00 10.00 10.00 10.00 11.00 10.00 11.00									
10.00 Hospi ce Conti nuous Home Care 0 0 0 0 0 0 10.00		DADT III FNDOLIMENT DAVO FOR	OOCT DEPORTING	DEDLODG BEGLA				4. 00	
11.00	10.00		COST REPORTING	PERIODS BEGIN	NNING ON OR AFT	ER OCTOBER I	· ·	0	10.00
12.00					1 301		٥	_	
13. 00 Hospi ce General Inpatient Care					1, 301				1
14. 00 Total Hospice Days 1,324 21 0 1,345 14. 00 PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15. 00 15. 0					18				
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015 15.00 Hospice Inpatient Respite Care 0 0 0 15.00						1	21 0		
			AL DATA FOR COS	ST REPORTING PE			R OCTOBER 1, 2015		1
16. 00 Hospice General Inpatient Care 0 0 0 0 16. 00	15. 00	Hospice Inpatient Respite Care			0		0 0	0	15. 00
	16. 00	Hospice General Inpatient Care			0	1	0 0	0	16. 00

	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN	: 15-1310	Peri od: From 01/01/2017	Worksheet S-10	0
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
					1. 00	
	Uncompensated and indigent care cost computation				0.070404	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide Medicaid (see instructions for each line)	ed by line	e 202 column	1 8)	0. 272134	1.
00	Net revenue from Medicaid				809, 127	2.
00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental		from Medica	ii d?	Υ	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid charges	Medi cai d			0 6, 637, 437	5. 6.
00	Medicaid cost (line 1 times line 6)				1, 806, 272	
00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus	sum of lir	es 2 and 5; if	997, 145	
	< zero then enter zero)					
00	Children's Health Insurance Program (CHIP) (see instructions for e Net revenue from stand-alone CHIP	each line)			0	9.
00	Stand-alone CHIP charges					
1. 00	Stand-alone CHIP cost (line 1 times line 10)				Ö	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (lin	ne 11 minu	ıs line 9; i	f < zero then	0	12.
	enter zero)	ations for	ا ما المورد			
3. 00	Other state or local government indigent care program (see instructive Net revenue from state or local indigent care program (Not include				1, 933, 958	13
1. 00	Charges for patients covered under state or local indigent care pr				9, 387, 451	
	10)					
5. 00	State or local indigent care program cost (line 1 times line 14)		Z1.1	45 ' ''	2, 554, 645	
5. 00	Difference between net revenue and costs for state or local indige 13; if < zero then enter zero)	ent care p	orogram (III	ie 15 minus line	620, 687	16.
						l
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/	Tocal indig	ent care progran	ns (see	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line)			ent care progran		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi	ing charit	y care	ent care progran	0	
7. 00 8. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ing charit pital oper	y care rations			18.
8. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ing charit pital oper	y care rations are programs	(sum of lines	0 0 1, 617, 832	18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in	ing charit pital oper	y care rations are programs	(sum of lines	0 0 1, 617, 832 Total (col. 1	
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in	ing charit pital oper	y care rations are programs	(sum of lines	0 0 1, 617, 832	18.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line)	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00	Insured patients 2.00	0 0 1,617,832 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ing charit pital oper ndigent ca	ry care rations are programs Uninsured patients	Insured patients 2.00	0 0 1,617,832 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions)	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00	Insured patients 2.00	0 0 1,617,832 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00	Insured patients 2.00	0 0 1,617,832 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00	Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170	18. 19. 20. 21.
3. 00 9. 00 0. 00 1. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00 1,032,20 280,89	Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011	18. 19. 20. 21. 22.
3. 00 9. 00 0. 00 1. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing charit pital oper ndigent ca	Uni nsured patients 1.00 1,032,20 280,89	Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011	18. 19. 20. 21. 22.
3. 00 2. 00 0. 00 1. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing charit pital oper ndigent ca	y care rations are programs Uninsured patients 1.00 1,032,20 280,89	Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011	18. 19. 20. 21. 22.
0. 00 0. 00 0. 00 0. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ing charit pital oper ndigent ca	Uni nsured pati ents 1.00 1,032,20 280,89 1,94	Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159	20. 21. 22. 23.
33. 00 9. 00 3. 00 11. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i	ing charit pital oper ndigent ca ity s (see f as	Uni nsured patients 1.00 1,032,20 280,89 278,99	(sum of lines Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159	20. 21. 22. 23.
00 00 00 00 00 00 00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the istay limit	ing charit pital oper ndigent ca	Uni nsured patients 1.00 1,032,20 280,89 278,99	(sum of lines Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159	20. 21. 22. 23. 24.
33. 00 30. 00 31. 00 32. 00 33. 00 44. 00 55. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i	ing charit pital oper ndigent ca ity s (see f as days beyor ogram? indigent ca	Uni nsured patients 1.00 1,032,20 280,89 1,94 278,95	(sum of lines Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159	20. 21. 22. 23. 24. 25.
33. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 37. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ing charit pital oper ndigent ca ity s (see f as days beyor ogram? indigent ca	Uni nsured patients 1.00 1,032,20 280,89 1,94 278,99 and a Length care program	(sum of lines Insured patients 2.00	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159 1.00 0 4, 052, 762 446, 580 687, 046	20. 21. 22. 23. 24. 25. 26. 27. 27.
33. 00 9. 00 1. 00 1. 00 4. 00 4. 00 6. 00 7. 00 7. 01 7. 01 7. 01	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ing charit pital oper ndigent ca ity s (see f as days beyor ogram? indigent cuctions) see instructi	Uni nsured patients 1.00 1,032,20 280,89 1,94 278,95 and a Length care program	Insured patients 2.00 25 628, 272 628, 272 625, 204 625, 204 625 6	0 0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159 1.00 4, 052, 762 446, 580 687, 046 3, 365, 716	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	ing charit pital oper ndigent ca ity s (see f as days beyor ogram? indigent cuctions) see instructi	Uni nsured patients 1.00 1,032,20 280,89 1,94 278,95 and a Length care program	Insured patients 2.00 25 628, 272 628, 272 625, 204 625, 204 625 6	0 0 1, 617, 832 Total (col. 1 + col. 2) 3.00 1, 660, 477 909, 170 5, 011 904, 159 1.00 0 4, 052, 762 446, 580 687, 046	20. 21. 22. 23. 24. 25. 26. 27. 28. 29.

Heal th	Financial Systems PA	ARKVIEW WABASH HO	OSPITAL, INC.		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	narad:
					10 12/31/201/	5/29/2018 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(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		8, 751, 889	8, 751, 88	•	8, 973, 012	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 558, 002	558, 002	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	76, 112	3, 701, 831			3, 777, 198	1
5.00	00500 ADMI NI STRATI VE & GENERAL	568, 270	10, 650, 881			11, 141, 415	1
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	247, 640	763, 110	1, 010, 75	0 -285 0 0	1, 010, 465 0	1
9. 00	00900 HOUSEKEEPING	205, 380	227, 121	432, 50	-	432, 501	9.00
10. 00	01000 DI ETARY	437, 295	263, 653			225, 978	
11. 00	01100 CAFETERI A	437, 273	203, 033	700, 74	0 469, 999	469, 999	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	378, 111	17, 976	396, 08		395, 022	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0,0,111	17, 770	0,0,00	0 1,000	070,022	1
15. 00	01500 PHARMACY	620, 640	583, 463	1, 204, 10	3 -85, 231	1, 118, 872	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	1, == 1, 15	0 0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		'	- 1		
30.00	03000 ADULTS & PEDIATRICS	1, 073, 563	621, 206	1, 694, 76	9 -512	1, 694, 257	30.00
43.00	04300 NURSERY	0	0		0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	532, 443	504, 243	1, 036, 68	6 -95, 215	941, 471	
51.00	05100 RECOVERY ROOM	0	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	
53. 00	05300 ANESTHESI OLOGY	0	44		-	44	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	800, 100	857, 393	1, 657, 49	-4, 662	1, 652, 831	1
56. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
60.00	06000 LABORATORY	0	1, 372, 222	1, 372, 22	2 0	1, 372, 222	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	1, 047, 426	154, 013	1, 201, 43		946, 841	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 89, 202	89, 202	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	E42 4E4	28, 606	571, 06	0 72, 866	72, 866	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	542, 456	697, 366			569, 325 370, 277	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	097, 300 O	1	0 326, 892	376, 277 326, 892	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 707, 571			1, 787, 378	1
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	1, 707, 371	1,707,37	17,007	1, 707, 370	73.00
90.00	09000 CLINIC	0	117, 752	117, 75	2 4, 971	122, 723	90.00
90. 01	09001 SENI OR CARE	147, 941	91, 785			239, 726	1
91. 00	09100 EMERGENCY	590, 705	2, 451, 215			3, 040, 914	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,			, ,	92.00
	OTHER REIMBURSABLE COST CENTERS	!		'	'		
101.00	10100 HOME HEALTH AGENCY	169, 783	42, 140	211, 92	3 0	211, 923	101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 I NTEREST EXPENSE		498, 011	498, 01	1 -498, 011	0	113. 00
116.00	11600 H0SPI CE	66, 316	108, 433				
118.00		7, 504, 181	34, 211, 924	41, 716, 10	5 0	41, 716, 105	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	37, 453	2, 787	40, 24			192. 00
	07950 FITNESS CENTER	0	0		0		194. 00
	07951 FOUNDATION	0	-185, 645	-185, 64	5 0	-185, 645	
	07952 NEW DIRECTION	이	0		0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	63, 388	63, 38			194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 04
	07955 OCCUPATIONAL HEALTH	7 541 (24	24 002 454		0		194. 05
200.00	TOTAL (SUM OF LINES 118 through 199)	7, 541, 634	34, 092, 454	41, 634, 08	8 0	41, 634, 088	J∠UU. UU

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1310

Peri od: Worksheet A From 01/01/2017 To 12/31/2017 Date/Time Prepared:

5/29/2018 9:58 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT -8, 668, 236 304, 776 1.00 513, 814 2.00 00200 CAP REL COSTS-MVBLE EQUIP -44, 188 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 -1, 126, 740 2, 650, 458 4.00 00500 ADMINISTRATIVE & GENERAL -3, 749, 476 7, 391, 939 5 00 5 00 7.00 00700 OPERATION OF PLANT -117, 993 892, 472 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 0 432, 501 9.00 01000 DI ETARY 10.00 225, 978 10.00 11.00 01100 CAFETERI A -167, 917 302, 082 11.00 13 00 01300 NURSING ADMINISTRATION 395, 022 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY -356, 003 762, 869 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17.434 30.00 1, 711, 691 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0 941, 471 05100 RECOVERY ROOM 51.00 0 r 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 05300 ANESTHESI OLOGY 53.00 44 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 -679, 607 973, 224 54.00 56.00 05600 RADI OI SOTOPE 56.00 60.00 06000 LABORATORY -85, 479 1, 286, 743 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06600 PHYSI CAL THERAPY 66.00 0 946, 841 66,00 67.00 06700 OCCUPATIONAL THERAPY 0 89, 202 67.00 06800 SPEECH PATHOLOGY 72, 866 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 569, 325 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 370, 277 71.00 72.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 326, 892 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 1, 787, 378 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 122, 723 90.00 90.01 09001 SENI OR CARE 0 239, 726 90.01 91.00 09100 EMERGENCY -648, 620 2, 392, 294 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 211, 923 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 113.00 116. 00 11600 HOSPI CE 0 174, 749 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -15, 626, 825 26, 089, 280 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 40, 240 192.00 194.00 07950 FITNESS CENTER 0 194.00 194. 01 07951 FOUNDATI ON 194 01 -185, 645 0 194.02 07952 NEW DIRECTION C 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 194. 03 63, 388 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 194. 04 0 194. 05 07955 OCCUPATIONAL HEALTH 194 05 200.00 TOTAL (SUM OF LINES 118 through 199) -15, 626, 825 26, 007, 263 200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1310

					0ate/11me Prepared: 5/29/2018 9:58 am
		Increases			 72772010 7. 00 dill
	Cost Center	Li ne #	Sal ary	Other	
	2. 00	3. 00	4. 00	5. 00	
	A - REHAB THERAPY RECLASS				
1.00	OCCUPATI ONAL THERAPY	67. 00	77, 767	11, 435	1. 00
2.00	SPEECH PATHOLOGY	68. 00	63, 525	9, 341	2. 00
	0		141, 292	20, 776	
	B - CLINIC DIETICIAN				
1.00	CLINIC	90.00	4, 971	0	1.00
	0		4, 971	O	
	C - CAFETERIA RECLASS				
1.00	CAFETERI A	1100	<u>291, 9</u> 52	17 <u>8, 0</u> 47	1. 00
	0		291, 952	178, 047	
	D - DRUGS CHARGED TO PATIENTS			<u>_</u>	
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	79, 807	1. 00
2.00		0.00	0	O	2. 00
3.00		0. 00	0	O	3. 00
4.00		0.00		0	4. 00
	0		0	79, 807	
	E - SALARY RECLASS				
1.00	ADMI NI STRATI VE & GENERAL		<u>2, 662, 5</u> 24	<u>0</u>	1.00
	0		2, 662, 524	0	
	G - DEPRECIATION				
1. 00	CAP REL COSTS-MVBLE EQUIP			405, 436	1.00
	0		0	405, 436	
	H - EQUIP & BLDG LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85, 800	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	124, 298	2. 00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7.00		0.00	O O	0	7. 00
8.00		0.00	O O	0	8. 00
9. 00 10. 00		0. 00 0. 00	0	0	9. 00 10. 00
10.00		0.00	O O	0	11.00
		0.00	0	0	
12. 00			0	<u>0</u> 210, 098	12. 00
	I - IMPLANTABLE MEDICAL SUP.		U	210, 090	
1.00	I MPL. DEV. CHARGED TO	72. 00	0	326, 892	1. 00
1.00	PATIENTS	72.00	۷	320, 092	1.00
	<u> </u>	+		326, 892	•
	J - RECLASS TAXES		<u> </u>	320, 072	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7, 569	1. 00
1.00	0 822 00313 0200 0 11X1		— — — }	$-\frac{7,507}{7,569}$	1.00
	K - INTEREST EXPENSE		<u> </u>	7,007	
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	498, 011	1. 00
50	0		— — — ў	498, 011	1.00
	L - I NSURANCE		٩	.,5,011	
1.00	CAP REL COSTS-BLDG & FLXT	1.00	ol	35, 179	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	ol o	28, 268	2.00
	0		— — o l-	63, 447	
500.00	Grand Total: Increases		3, 100, 739	1, 790, 083	500.00
	1	ı	-, , . 9 /	/ /	1 = = 3.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1310

| Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/29/2018 9:58 am

						5/29/2018 9:58 am
		Decreases		0.11		
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - REHAB THERAPY RECLASS					
1.00	PHYSI CAL THERAPY	66.00	141, 292	20, 776	1	1.0
2.00		0.00	0	0		2.0
	0		141, 292	20, 776		
	B - CLINIC DIETICIAN					
1. 00	DI ETARY	1000	4, 971	0	0	1.0
	0		4, 971	0		
	C - CAFETERIA RECLASS	40.00	204 250	470.047		
1. 00	DI ETARY	1000	291, 952	17 <u>8, 0</u> 47		1.0
	O DRIVER OUR DOED TO DATE THE		291, 952	178, 047		
	D - DRUGS CHARGED TO PATIENTS	45.00		75.050		
1.00	PHARMACY	15. 00	0	75, 352		1.0
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 217		2. 0
3.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	197	0	3.0
	PATIENT	24 22				
4.00	EMERGENCY	91.00	0	41		4.0
	0		0	79, 807		
4 00	E - SALARY RECLASS	5 00l		0 //0 504		1.0
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>2, 662, 524</u>		1.0
	0		0	2, 662, 524		
4 00	G - DEPRECIATION	4 00		105 107		
1.00	CAP REL COSTS-BLDG & FIXT	1.00		40 <u>5, 4</u> 36		1.0
	U FOULD & BLDG LEAGE		0	405, 436		
1 00	H - EQUIP & BLDG LEASE	// 00	ما	05.000	10	1.0
1.00	PHYSI CAL THERAPY	66.00	0	85, 800		1.0
2.00	RADI OLOGY-DI AGNOSTI C	54. 00 4. 00	0	445 745	1	2. 0
3.00	EMPLOYEE BENEFITS DEPARTMENT					3. 0
4.00	ADMI NI STRATI VE & GENERAL	5.00	0	6, 720	1	4. 0
5.00	OPERATION OF PLANT	7.00	0	285	1	5. 0
6.00	NURSI NG ADMI NI STRATI ON	13.00	0	1, 065		6. 0
7.00	PHARMACY	15. 00	0	9, 879	1	7. 0
8.00	ADULTS & PEDIATRICS	30.00	0	512	1	8. 0
9.00	OPERATING ROOM	50.00	0	95, 215		9.0
10.00	ELECTROCARDI OLOGY	69.00	0	1, 737	1	10.0
11.00	PHYSI CAL THERAPY	66.00	0	6, 730		11.0
12. 00	EMERGENCY	<u>91.</u> 00	0	965		12.0
	0		0	210, 098		
	I - IMPLANTABLE MEDICAL SUP.					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	326, 892	0	1.0
	PATI ENT	+	_ — — 🖶		 	
	0		0	326, 892		
	J - RECLASS TAXES			7.540		
1. 00	ADMI NI STRATI VE & GENERAL					1.0
	0		0	7, 569	1	
	K - INTEREST EXPENSE	440.00		100 011	1	
1. 00	INTEREST EXPENSE	113.00	0	498, 011		1.0
	0 LANGUEANOE		0	498, 011		
	L - INSURANCE	ادم م			10	
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	63, 447		1.0
2.00		0.00		0		2.0
	0		0	63, 447		
	Grand Total: Decreases		438, 215	4, 452, 607	1	500. 0

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS In Lieu of Form CMS-2552-10 Provider CCN: 15-1310

						5/29/2018 9:5	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				_		
1.00	Land	1, 295, 014	0	0	0	0	1. 00
2.00	Land Improvements	314, 699	0	0	0	0	2. 00
3.00	Buildings and Fixtures	12, 586, 529	0	0	0	0	3. 00
4.00	Building Improvements	4, 150, 859		0	0	0	4. 00
5.00	Fi xed Equipment	921, 093	0	0	0	0	5. 00
6.00	Movable Equipment	14, 181, 638	321, 735	0	321, 735	4, 931	6. 00
7.00	HIT designated Assets	2, 108, 409	199, 434	0	199, 434	6, 475	7. 00
8.00	Subtotal (sum of lines 1-7)	35, 558, 241	521, 169	0	521, 169	11, 406	8. 00
9.00	Reconciling Items	10, 046	299, 271	0	299, 271	0	9. 00
10.00	Total (line 8 minus line 9)	35, 548, 195	221, 898	0	221, 898	11, 406	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 295, 014		l			1. 00
2.00	Land Improvements	314, 699					2. 00
3.00	Buildings and Fixtures	12, 586, 529	12, 521, 286				3. 00
4.00	Building Improvements	4, 150, 859	2, 749, 486				4.00
5.00	Fi xed Equipment	921, 093	644, 215				5. 00
6.00	Movable Equipment	14, 498, 442	11, 828, 723				6. 00
7.00	HIT designated Assets	2, 301, 368	1, 476, 650				7. 00
8.00	Subtotal (sum of lines 1-7)	36, 068, 004	29, 432, 089				8. 00
9.00	Reconciling Items	309, 317					9. 00
10.00	Total (line 8 minus line 9)	35, 758, 687	29, 432, 089				10.00

Health Financial Systems PA	RKVIEW WABASH	HOSPITAL, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-1310	Peri od:	Worksheet A-7	
				From 01/01/2017	Part II	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
			SUMMARY OF CAP	PI TAI	372772010 7. 3	Jani
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10.00	11.00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	8, 744, 320		0	0	7, 569	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0		0	0	0	2. 00
3.00 Total (sum of lines 1-2)	8, 744, 320		0	0 0	7, 569	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (su	ım			
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	8, 751, 88	19			1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0		0			2. 00
3.00 Total (sum of lines 1-2)	0	8, 751, 88	19			3. 00

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Peri od: Worksheet A-7 From 01/01/2017 Part III To 12/31/2017 Date/Time Pre 5/29/2018 9:5		
		COMI	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	19, 268, 194	l .	19, 268, 19			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 498, 443	l	14, 498, 44			2. 00
3.00	Total (sum of lines 1-2)	33, 766, 637		33, 766, 63			3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPI						F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5	i i		
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 168, 659		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 361, 248	124, 298	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 529, 907	217, 667	3. 00
			SL	IMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	'		instructions)	instructions	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	00, ,			304, 776	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28, 268		0	513, 814	2. 00
3.00	Total (sum of lines 1-2)	0	63, 447	7, 56	9 0	818, 590	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-1310

				11	0 12/31/2017	Date/lime Prep 5/29/2018 9:58	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1 00		1.00	2.00	3. 00	4. 00	5. 00	4 0
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		U	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		O		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00		6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7. 00
8. 00	Tel evi si on and radi o servi ce (chapter 21)	А	-4, 351	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -651, 399		0.00	0	9. 00 10. 00
	adjustment Sale of scrap, waste, etc.	7. 5.2	0		0. 00		
11. 00	(chapter 23)				0.00	0	
12. 00	Related organization transactions (chapter 10)	A-8-1	-3, 680, 068			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	147 017	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		-167, 917	CAFETERIA	0.00	0	15. 00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than	В	-356, 003	PHARMACY	15. 00	0	17. 00
	patients						
18. 00	Sale of medical records and abstracts		0		0.00		18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	0	OPERATION OF PLANT	7. 00		
21. 00	Income from imposition of interest, finance or penalty		U		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to				2.23		
23. 00	, ,	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)				444.00		05.04
25. 00	Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		O	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	O	OCCUPATI ONAL THERAPY	67. 00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
J 1. UU	pathology costs in excess of	A-0-3	U	OI LEGIT I ATTIOLOGI	00.00		J 1. U
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		O		0. 00	0	32. 00

From 01/01/2017
To 12/31/2017 Date/Time Prepared:

				'	0 12/31/2017	5/29/2018 9:5	
	·			Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	DEPRECIATION HIT ASSETS	A	-54, 759	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	2016					_	
33. 01		A	-44, 188	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 01
0.4.00	PRI OR		0 077	ADMINISTRATIVE & OFNEDAL	F 00		04.00
34.00	RECRUITMENT	A	•	ADMINISTRATIVE & GENERAL	5.00	-	34.00
38. 00	SELF INSURANCE ADJUSTMENT	A	· ·	EMPLOYEE BENEFITS DEPARTMENT	4.00	-	38. 00
39. 00	LOBBYING	A	•	ADMI NI STRATI VE & GENERAL	5. 00		39. 00
40. 00	MARKETI NG	A		ADMI NI STRATI VE & GENERAL	5. 00		10.00
42. 00	LI QUOR ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00		42. 00
44. 00	DEPRECIATION REDUCTION FOR	A	-8, 170, 225	CAP REL COSTS-BLDG & FIXT	1.00	9	44. 00
	ACCELERAT			l		_	
45. 00	TELEMETRY MONITORING	Α	•	ADULTS & PEDIATRICS	30. 00		10.00
	FI TNESS CENTER	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		
45. 02	PURCHASI NG DI SCOUNTS	A		ADMINISTRATIVE & GENERAL	5. 00		45. 02
46. 01	CAPITALIZED INTEREST EXPENSE	A	•	CAP REL COSTS-BLDG & FIXT	1.00		
48. 00	OTHER OPERATING REV	A	•	RADI OLOGY-DI AGNOSTI C	54. 00		10.00
49. 00	OTHER OPERATING REV	A		LABORATORY	60.00		49. 00
49. 01	REMOVE EMS INTERSUBISDY	A		ADMINISTRATIVE & GENERAL	5. 00		
49. 05	PHYSICIAN CLINIC RENT OFFSET	В	-113, 642	OPERATION OF PLANT	7. 00	0	49. 05
50.00	TOTAL (sum of lines 1 thru 49)		-15, 626, 825				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.

* 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.

6, 236, 867

9, 916, 935

5.00

 both posted to methodot 71, our amino i ana, or 2, the amount arrowable chourd be interested in coramin i or this parti								
			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

6. 00	В	0. 00 PARKVI EW HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10. 00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

5.00

line 12.

TOTALS (sum of lines 1-4).

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

Health Financial Systems			PARKVIEW WABASH HOSPITAL, INC.				In Lieu of Form CMS-2552		
STATEME OFFICE		SERVICES FROM	RELATED ORGANI ZA	ATIONS AND HOME	Provider CCN:	15-1310	Peri od: From 01/01/2017	Worksheet A-	8-1
							To 12/31/2017	Date/Time Pr 5/29/2018 9:	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS	S A RESULT OF TRA	NSACTIONS WITH	RELATED C	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	980, 867	0							1.00
2.00	-4, 660, 935	0							2.00
3.00	0	0							3.00
4.00	0	0							4.00
5.00	-3, 680, 068								5. 00
* The	amounts on line	es 1-4 (and sub	scripts as appro	opriate) are trans	sferred in deta	ail to Wor	ksheet A, column	6 lines as	
							ganization or hom		whi ch
							ated in column 4		
1.00	<u> </u>	ani zati on(s)	23. G 2 1 Grid/ 01	Z, the amount a		2 20 71101 0	a coa oor amir 1	5. t5 par t.	
		me Office							
	4.147 01 110	011166							

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

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

6.00	HEALTH SYSTEM	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10. 00
10. 00 100. 00		100.00

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

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

Type of Business

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

| Period: | Worksheet A-8-2 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1310

							To 12/31/2013	7 Date/Time Pre 5/29/2018 9:5	
	Wkst. A Line #	Cost	: Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	Jo din
			I denti fi er	Remuneration	Component	Component		ider Component	
						·		Hours	
	1. 00		2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	91. 00 DR			40, 000					
2.00	91. 00 DR			1, 678, 241					
3.00	30. 00 DR			9, 900	C	.,		0	
4.00	90. 01 DR			20, 851	C	20,00.	(0	4. 00
5.00	5. 00 DR	. Е		2, 779	2, 779) c	0	5. 00
6.00	0. 00			0	C	0)	0	6. 00
7.00	0. 00			0	C	0)	0	7. 00
8.00	0. 00			0	C	0)	0	8. 00
9.00	0. 00			0	C)) (0	9. 00
10.00	0. 00			0	C)	0	0	10.00
200.00				1, 751, 771	651, 399	1, 100, 372	2	0	200.00
	Wkst. A Line #	Cost		Unadjusted RCE		Cost of	Provi der	Physician Cost	
			l denti fi er	Limit		Memberships &		of Malpractice	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00		2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00	91. 00 DR			0		_	1		
2.00	91. 00 DR			0	1	1	0	1	2. 00
3.00	30. 00 DR			0	· · · · · ·	1		0	
4.00	90. 01 DR			0	C	1)	0	
5.00	5. 00 DR	. Е		0	C))	0	
6. 00	0.00			0	C	0)	0	
7. 00	0.00			0	C	0)	0	
8. 00	0.00			0	C	0)	0	
9. 00	0.00			0	C	0)	0	
10.00	0.00			0	C	0)	0	
200.00				0	C) (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	91. 00 DR	Δ	2. 00	15.00					1. 00
2. 00	91. 00 DR								2. 00
3.00	30. 00 DR						040,020	1	3.00
4. 00	90. 01 DR					1		1	4. 00
5.00	5. 00 DR					1	2, 779	1	5. 00
6. 00	0. 00	. ∟				1	2,779		6. 00
7. 00	0.00								7. 00
7. 00 8. 00	0.00								8.00
9. 00	0.00								9.00
9. 00 10. 00	0.00								10.00
	0.00						651, 399		200.00
200.00	1			ı	լ) (ו כס ו, אין	'	₁ ∠00. 00

Provider CCN: 15-1310

Period: Worksheet B
From 01/01/2017 Part / I

					From 01/01/2017 To 12/31/2017		pared:
			CAPI TAL REI	LATED COSTS		37 2 77 2010 7. 3	O alli
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4/1	
1.00	00100 CAP REL COSTS-BLDG & FIXT	304, 776	304, 776				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	513, 814		513, 81	4		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 650, 458	2, 047				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 391, 939	85, 125	1		8, 467, 809	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	892, 472 0	6, 970 0		0 64, 941	976, 133 0	1
9. 00	00900 HOUSEKEEPING	432, 501	6, 016	1	-	502, 518	1
10. 00	01000 DI ETARY	225, 978	12, 188			295, 524	10.00
11. 00	01100 CAFETERI A	302, 082	3, 780			388, 795	11. 00
13.00	01300 NURSING ADMINISTRATION	395, 022	5, 178	8, 73	99, 155	508, 085	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	9, 813			26, 357	14. 00
15. 00	01500 PHARMACY	762, 869	15, 611			967, 553	1
16. 00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	16. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 711, 691	30, 490	51, 40	2 281, 529	2, 075, 112	30. 00
43. 00	04300 NURSERY	0	0	1	0 0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	941, 471	25, 137	42, 37	139, 627	1, 148, 613	1
51. 00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	70	0	0	52.00
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	973, 224	420 17, 445	•		1, 173 1, 229, 895	
56. 00	05600 RADI OI SOTOPE	973, 224	17, 445	27, 40	209, 617	1, 229, 693	56.00
60. 00	06000 LABORATORY	1, 286, 743	7, 425	12, 51	7 0	1, 306, 685	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	946, 841	1, 416	2, 38	7 237, 623	1, 188, 267	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	89, 202	0	1	20, 393	109, 595	67. 00
68. 00	06800 SPEECH PATHOLOGY	72, 866	0 074	15 20	16, 659	89, 525	1
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	569, 325 370, 277	9, 074 0	15, 29	7 142, 253	735, 949 370, 277	69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	326, 892	0			326, 892	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 787, 378	0		0	1, 787, 378	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	122, 723	0		1, 304	124, 027	90.00
90. 01	09001 SENI OR CARE	239, 726	3, 645	1		288, 312	1
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 392, 294	6, 449	10, 87	2 154, 905	2, 564, 520 0	ı
92.00	OTHER REIMBURSABLE COST CENTERS					0	92.00
101.00	10100 HOME HEALTH AGENCY	211, 923	2, 227	3, 75	4 44, 524	262, 428	101. 00
	SPECIAL PURPOSE COST CENTERS		·				
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	174, 749	0		17, 391	192, 140	116. 00
118.00		26, 089, 280	250, 456	422, 23	8 2, 646, 134	25, 933, 562	J118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 966	3, 31	5 0	5 291	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	40, 240	38, 141			152, 503	1
	07950 FITNESS CENTER	0	9, 492				194. 00
194. 01	07951 FOUNDATI ON	-185, 645	1, 344			-182, 035	194. 01
	07952 NEW DIRECTION	0	0	l .	0 0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	63, 388	258				194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	3, 119	5, 25	S 0		194. 04
194. 05 200. 00	07955 OCCUPATIONAL HEALTH Cross Foot Adjustments		0	1	J 0		194. 05 200. 00
200.00			0		ار ا		200.00
202.00		26, 007, 263	304, 776	513, 81	4 2, 655, 956		
							•

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/29/2018 9:58 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 8 467 809 5 00 7.00 00700 OPERATION OF PLANT 468, 489 1, 444, 622 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 241, 180 51.315 0 795, 013 9.00 01000 DI ETARY 0 59.314 600, 624 10.00 10.00 141, 835 103, 951 11.00 01100 CAFETERI A 186, 600 32, 240 0 18, 396 0 11.00 13 00 01300 NURSING ADMINISTRATION 243, 852 44, 167 0 25, 201 0 13.00 01400 CENTRAL SERVICES & SUPPLY 83, 702 0 47, 760 14 00 12,650 14.00 0 0 15.00 01500 PHARMACY 464, 371 133, 151 75, 975 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 148.386 600, 624 30.00 03000 ADULTS & PEDIATRICS 995, 938 260, 054 0 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 551, 270 214, 400 122, 335 0 05100 RECOVERY ROOM 0 51.00 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0 53.00 563 3, 585 2,045 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 84, 898 54.00 590, 281 148, 789 0 54.00 56.00 05600 RADI OI SOTOPE 0 56.00 60.00 06000 LABORATORY 627, 136 63, 326 0 36, 134 0 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06600 PHYSI CAL THERAPY 0 66,00 570.302 12,074 6,889 0 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 52, 599 0 67.00 06800 SPEECH PATHOLOGY 42, 967 0 68.00 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 353. 214 0 69.00 77.392 44, 159 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 177, 712 C 0 0 72.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 156, 890 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 857, 841 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 59, 526 0 0 0 90.01 09001 SENI OR CARE 138, 374 31, 087 0 17, 738 0 90.01 91.00 09100 EMERGENCY 1, 230, 833 55.004 0 31, 385 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 125, 951 18, 992 10, 837 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 92, 216 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 382, 590 1, 333, 229 0 600, 624 118. 00 731, 452 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,535 16, 770 0 9, 569 192.00 19200 PHYSICIANS' PRIVATE OFFICES 35, 673 0 0 192.00 194.00 07950 FITNESS CENTER 80, 956 0 46, 193 0 194.00 12, 236 0 194. 01 07951 FOUNDATI ON 0 194 01 0 11, 466 6, 543 194.02 07952 NEW DIRECTION 0 0 0 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 30.755 0 0 194. 03 2, 201 1.256 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 04 4.020 C 0 194. 05 07955 OCCUPATI ONAL HEALTH 0 C 0 0 0 194 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 1.444,622 0 795.013 600, 624 202. 00 202.00 TOTAL (sum lines 118 through 201) 8, 467, 809

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

					12/31/2017	5/29/2018 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						_
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					I	2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
	l l					I	1
5.00	00500 ADMINISTRATIVE & GENERAL					I	5. 00
7.00	00700 OPERATION OF PLANT					I	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					I	8. 00
9. 00	00900 HOUSEKEEPI NG					I	9. 00
10. 00	01000 DI ETARY					I	10.00
11. 00	O1100 CAFETERI A	626, 031				I	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	30, 306	851, 611			I	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	170, 469		I	14. 00
15. 00	01500 PHARMACY	53, 722	ol	11, 655	1, 706, 427	I	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	ol	0	ol	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		- 1	-	- 1		
30. 00	03000 ADULTS & PEDIATRICS	126, 074	425, 976	9, 076	271	0	30.00
43. 00	04300 NURSERY	0	120, 770	0	0		
43.00	ANCI LLARY SERVI CE COST CENTERS	0	<u> </u>	O _I	<u> </u>	0	45.00
50. 00	05000 OPERATING ROOM	57, 040	192, 753	28, 688	115, 407	0	50.00
		37,040	192, 703	20, 000			1
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53. 00	05300 ANESTHESI OLOGY	0	0	0	2, 514	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	92, 897	0	4, 178	4, 624	0	
56.00	05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66. 00	06600 PHYSI CAL THERAPY	0	0	3, 573	14, 999	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 104	o	260	1, 131	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	5, 551	ol	0	242	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	169, 267	0	1, 421		i o	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	53, 090	ő	o o	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	41, 788	Ö	Ö	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	o	41, 700	1, 567, 096	0	1
73.00	OUTPATIENT SERVICE COST CENTERS		U U	U _I	1, 307, 090	0	73.00
90. 00	09000 CLINIC	574	ol	1.2	ol	0	00.00
	1 1		U	12			
90. 01	09001 SENI OR CARE	16, 589	000 000	67	0	0	
91. 00	09100 EMERGENCY	68, 907	232, 882	15, 005	143	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	T					4
101.00	10100 HOME HEALTH AGENCY	0	0	1, 157	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE					I	113. 00
116. 00	11600 H0SPI CE	0	0	383	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	626, 031	851, 611	170, 353	1, 706, 427	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	ol	111	ol	0	192. 00
	07950 FITNESS CENTER	0	o	0	ol		194. 00
	07951 FOUNDATI ON	0	o	0	o		194. 01
	07952 NEW DIRECTION	0	o	0	0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES		ا	5	٥		194. 02
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	5	o		194. 04
	07955 OCCUPATIONAL HEALTH			0	Š		194. 04
200.00	1 1		l 4	U	Ч	ı	
	1 1	_	ا				200. 00
201.00		(2/ 021	054 (44	170 40	1 70/ 407		201. 00
202.00	TOTAL (sum lines 118 through 201)	626, 031	851, 611	170, 469	1, 706, 427	. 0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310

				Fr To	o 12/31/2017 Part I Date/Time Pr 5/29/2018 9:	
Cos	st Center Description	Subtotal R	Intern & Residents Cost & Post Stepdown Adjustments	Total	70,27,2010 7.	
		24. 00	25. 00	26. 00		
	SERVI CE COST CENTERS					
2. 00 00200 CAI 4. 00 00400 EMI 5. 00 00500 ADI 7. 00 00700 OPI 8. 00 00800 LAI 9. 00 00900 HOI 11. 00 01100 CAI 13. 00 01300 NUI 14. 00 01400 CEI 15. 00 01600 MEI	FETERIA RSING ADMINISTRATION NTRAL SERVICES & SUPPLY					1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00 03000 ADI	ULTS & PEDIATRICS	4, 641, 511	0	4, 641, 511		30.00
43. 00 04300 NUI	RSERY	0	0	0		43. 00
ANCI LLAR	Y SERVICE COST CENTERS					
50. 00 05000 OPI	ERATING ROOM	2, 430, 506	0	2, 430, 506		50. 00
51. 00 05100 RE	COVERY ROOM	0	0	0		51. 00
52. 00 05200 DEI	LIVERY ROOM & LABOR ROOM	0	0	0		52. 00
53. 00 05300 ANI	ESTHESI OLOGY	9, 880	0	9, 880		53. 00
54. 00 05400 RAI	DI OLOGY-DI AGNOSTI C	2, 155, 562	O	2, 155, 562		54.00
56. 00 05600 RAI	DI OI SOTOPE	0	0	0		56. 00
60. 00 06000 LAI	BORATORY	2, 033, 281	O	2, 033, 281		60.00
63. 00 06300 BL	OOD STORING, PROCESSING & TRANS.	0	О	0		63.00
66. 00 06600 PH	YSI CAL THERAPY	1, 796, 104	O	1, 796, 104		66. 00
	CUPATI ONAL THERAPY	168, 689	o	168, 689		67. 00
	EECH PATHOLOGY	138, 285	o	138, 285		68. 00
69. 00 06900 ELI	ECTROCARDI OLOGY	1, 381, 402	o	1, 381, 402		69. 00
	DICAL SUPPLIES CHARGED TO PATIENT	601, 079	o	601, 079		71. 00
	PL. DEV. CHARGED TO PATIENTS	525, 570	o	525, 570		72. 00
	UGS CHARGED TO PATIENTS	4, 212, 315	o	4, 212, 315		73. 00
	NT SERVICE COST CENTERS	., ,	-1	., = . = , =		
90. 00 09000 CL		184, 139	0	184, 139		90.00
	NI OR CARE	492, 167	o	492, 167		90. 01
91. 00 09100 EMI		4, 198, 679	o	4, 198, 679		91. 00
	SERVATION BEDS (NON-DISTINCT PART	.,,	o	.,,		92. 00
	IMBURSABLE COST CENTERS					
	ME HEALTH AGENCY	419, 365	0	419, 365		101. 00
	PURPOSE COST CENTERS					
113. 00 11300 I N						113. 00
116. 00 11600 HOS		284, 739	0	284, 739		116. 00
	BTOTALS (SUM OF LINES 1 through 117)	25, 673, 273	o	25, 673, 273		118. 00
	URSABLE COST CENTERS		-1			
	FT, FLOWER, COFFEE SHOP & CANTEEN	34, 155	0	34, 155		190. 00
	YSI CI ANS' PRI VATE OFFI CES	188, 287	o	188, 287		192. 00
194. 00 07950 FI		164, 879	Ö	164, 879		194. 00
194. 01 07951 FO		-164, 026	Ö	-164, 026		194. 01
194. 02 07952 NEV		0	Ö	0		194. 02
	MMUNITY & VOLUNTEER SERVICES	98, 298	o	98, 298		194. 03
	HER NONREIMBURSABLE COST CENTERS	12, 397	ol	12, 397		194. 04
	CUPATI ONAL HEALTH	0	o	0		194. 05
	oss Foot Adjustments	Ö	Ö	Ö		200. 00
	gative Cost Centers	Ö	Ö	Ö		201. 00
	TAL (sum lines 118 through 201)	26, 007, 263	Ö	26, 007, 263		202. 00
	9 ,					•

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared:

				To	12/31/2017	Date/Time Pre	pared:
			CAPLTAL REI	ATED COSTS		5/29/2018 9:5	8 am
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DEI ARTIMENT	
		0	1. 00	2.00	2A	4. 00	
	RAL SERVICE COST CENTERS O CAP REL COSTS-BLDG & FIXT						1 00
	O CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
	O EMPLOYEE BENEFITS DEPARTMENT	0	2, 047	3, 451	5, 498	5, 498	4. 00
1	O ADMINISTRATIVE & GENERAL	633, 683	85, 125		862, 321	1, 754	5. 00
	O OPERATION OF PLANT	0	6, 970	11, 750	18, 720	134	7. 00
	O LAUNDRY & LINEN SERVICE	0	0	-	0	0	8. 00
	O HOUSEKEEPI NG	0	6, 016		16, 159	112	9.00
1	O DI ETARY O CAFETERI A	0	12, 188 3, 780		32, 735 10, 152	76 159	10. 00 11. 00
1	O NURSI NG ADMI NI STRATI ON	0	5, 780 5, 178		13, 908	205	13. 00
1	O CENTRAL SERVICES & SUPPLY	0	9, 813		26, 357	0	14. 00
15. 00 0150	O PHARMACY	0	15, 611		41, 929	337	15. 00
	O MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	TIENT ROUTINE SERVICE COST CENTERS		20.400	F4 400	04 000	F00	00.00
	O ADULTS & PEDIATRICS O NURSERY	0	30, 490 0		81, 892 0	583 0	30. 00 43. 00
	LLARY SERVICE COST CENTERS	U	0	UU	U	0	43.00
	O OPERATING ROOM	0	25, 137	42, 378	67, 515	289	50. 00
51. 00 0510	O RECOVERY ROOM	0	0	0	0	0	51. 00
	O DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	O ANESTHESI OLOGY	0	420		1, 129	0	53. 00
	O RADI OLOGY-DI AGNOSTI C O RADI OI SOTOPE	0	17, 445 0	29, 409	46, 854 0	434 0	54. 00 56. 00
	O LABORATORY	0	7, 425	-	19, 942	0	60.00
	O BLOOD STORING, PROCESSING & TRANS.	0	0	12, 317	0	0	63. 00
	O PHYSI CAL THERAPY	0	1, 416	2, 387	3, 803	492	66. 00
	O OCCUPATI ONAL THERAPY	0	0	0	0	42	67. 00
	O SPEECH PATHOLOGY	0	0	0	0	34	68. 00
	O ELECTROCARDI OLOGY	0	9, 074	·	24, 371	295	69.00
	O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	O DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	ATIENT SERVICE COST CENTERS			-1			
	O CLI NI C	0	0	0	0	3	90. 00
1	1 SENI OR CARE	0	3, 645		9, 790	80	90. 01
	O EMERGENCY	0	6, 449	10, 872	17, 321	321	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS				0		92. 00
	O HOME HEALTH AGENCY	0	2, 227	3, 754	5, 981	92	101. 00
	I AL PURPOSE COST CENTERS		2,227	0,701	3, 701	,,,	101.00
113. 00 1130	O I NTEREST EXPENSE						113. 00
116. 00 1160		0	0		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	633, 683	250, 456	422, 238	1, 306, 377	5, 478	118. 00
	EIMBURSABLE COST CENTERS OGIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 966	3, 315	5, 281	0	190. 00
	O PHYSICIANS' PRIVATE OFFICES	0	38, 141		102, 441		190.00
	O FITNESS CENTER	0	9, 492		25, 494		194. 00
	1 FOUNDATION	0	1, 344		3, 610		194. 01
1	2 NEW DIRECTION	0	0		0		194. 02
1	3 COMMUNITY & VOLUNTEER SERVICES	0	258		693		194. 03
1	6 OTHER NONREIMBURSABLE COST CENTERS	0	3, 119	5, 258	8, 377		194. 04 194. 05
200. 00	5 OCCUPATIONAL HEALTH Cross Foot Adjustments		0		0	Ü	200. 00
201.00	Negative Cost Centers		0	0	0	0	200.00
202. 00	TOTAL (sum lines 118 through 201)	633, 683	304, 776	513, 814	1, 452, 273		202. 00
•		'					

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2017 | Part II |
| To | 12/31/2017 | Date/Time Prepared: | 5/29/2018 9:58 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

						5/29/2018 9:5			
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY			
		& GENERAL	PLANT	LINEN SERVICE					
	T	5. 00	7. 00	8. 00	9. 00	10. 00			
	GENERAL SERVICE COST CENTERS	Т		T					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00		
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00		
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0/4 075					4. 00		
5.00	00500 ADMINISTRATIVE & GENERAL	864, 075	// //0				5.00		
7.00	00700 OPERATION OF PLANT	47, 806	66, 660				7.00		
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	_			8.00		
10.00	01000 DI ETARY	24, 611 14, 473	2, 368 4, 797			55, 308	9. 00 10. 00		
11. 00	01100 CAFETERI A	19, 041	1, 488			0 35, 306	11.00		
13. 00	01300 NURSING ADMINISTRATION	24, 883	2, 038			0	13.00		
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 291	3, 862				14. 00		
15. 00	01500 PHARMACY	47, 386	6, 144		,		15. 00		
16. 00	01600 MEDICAL RECORDS & LIBRARY	47, 300	0, 144	1	.,	0	16.00		
10.00	OTBOU MEDICAL RECORDS & LIBRARY O O O O TELLON TO STAND O O O O O O O O O O O O O O O O O O								
30. 00	03000 ADULTS & PEDIATRICS	101, 629	12, 000	0	8, 072	55, 308	30. 00		
43. 00	04300 NURSERY	0	0	•			43. 00		
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · ·							
50.00	05000 OPERATI NG ROOM	56, 253	9, 893	0	6, 655	0	50.00		
51.00	05100 RECOVERY ROOM	O	0	0	0	0	51.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	0	0	0	0	52. 00		
53.00	05300 ANESTHESI OLOGY	57	165	0	111	0	53.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	60, 234	6, 866	0	4, 619	0	54.00		
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00		
60.00	06000 LABORATORY	63, 995	2, 922	0	1, 966	0	60.00		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	_	0	63. 00		
66. 00	06600 PHYSI CAL THERAPY	58, 195	557	0			66. 00		
67. 00	06700 OCCUPATI ONAL THERAPY	5, 367	0	1	_	0	67. 00		
68. 00	06800 SPEECH PATHOLOGY	4, 384	0	1	_	0	68. 00		
69. 00	06900 ELECTROCARDI OLOGY	36, 043	3, 571			0	69. 00		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 134	0	_	_	0	71.00		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 010	0				72.00		
73. 00	07300 DRUGS CHARGED TO PATIENTS	87, 537	0	0	0	0	73. 00		
00 00	OUTPATIENT SERVICE COST CENTERS	4 074	0	0	0	0	90.00		
90. 00 90. 01	09000 CLI NI C 09001 SENI OR CARE	6,074				-	90.00		
91.00	09100 EMERGENCY	14, 120 125, 594	1, 434			0	91.00		
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	125, 594	2, 538	1	1, 707	0	91.00		
92.00	OTHER REIMBURSABLE COST CENTERS						72.00		
101 00	10100 HOME HEALTH AGENCY	12, 852	876	0	590	0	101. 00		
101.00	SPECIAL PURPOSE COST CENTERS	12,032	070		370		1101.00		
113.00	11300 I NTEREST EXPENSE						113. 00		
	11600 HOSPI CE	9, 410	0	0	0	0	116. 00		
118.00	1 1	855, 379	61, 519	•		55, 308			
	NONREI MBURSABLE COST CENTERS				,				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	259	774	0	521	0	190. 00		
	19200 PHYSICIANS' PRIVATE OFFICES	3, 640	0	0	0	0	192. 00		
194.00	07950 FITNESS CENTER	1, 249	3, 736	0	2, 513	0	194. 00		
194.01	07951 FOUNDATION	O	529	0	356	0	194. 01		
	07952 NEW DIRECTION	O	0		0		194. 02		
	07953 COMMUNITY & VOLUNTEER SERVICES	3, 138	102	0	68		194. 03		
	07956 OTHER NONREIMBURSABLE COST CENTERS	410	0				194. 04		
	07955 OCCUPATI ONAL HEALTH	0	0	0	0	0	194. 05		
200.00	, ,						200. 00		
201.00		0	0				201. 00		
202.00	TOTAL (sum lines 118 through 201)	864, 075	66, 660	0	43, 250	55, 308	J202. 00		

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | Part II | Part II | Prepared: | Part II | Part II | Prepared: | Part II | Part II | Prepared: | Part II | Part II | Prepared: | Part II | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

				То	12/31/2017	Date/Time Pre 5/29/2018 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	diii
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	04 044					10.00
11.00	01100 CAFETERI A	31, 841	1				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 541	43, 946	0.4.400			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0.700		34, 108	404 000		14.00
15. 00	01500 PHARMACY	2, 732	1	2, 332	104, 993	0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	C	y y	0	U	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 412	21, 981	1, 816	17	0	30. 00
43. 00	04300 NURSERY	0, 412 C	1	1, 610	0	0	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		<u>/</u>	U _I	<u> </u>	0	43.00
50. 00	05000 OPERATING ROOM	2, 901	9, 947	5, 740	7, 101	0	50. 00
51. 00	05100 RECOVERY ROOM	2,70.	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	ol ol	0	o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	C	ol ol	0	155	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 725	ol	836	285	0	54. 00
56. 00	05600 RADI OI SOTOPE	., c	1	0	0	0	56. 00
60.00	06000 LABORATORY	C	o	0	O	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	o	0	0	0	63. 00
66.00	06600 PHYSI CAL THERAPY	C	o	715	923	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	260	0	52	70	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	282	. 0	0	15	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 610	0	284	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C		10, 624	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C		8, 361	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	C	0	0	96, 418	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0.0	ا		ام		00.00
90.00	09000 CLINIC	29		2	0	0	90.00
90. 01	09001 SENI OR CARE	844	1	13	O O	0	90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 505	12, 018	3, 002	9	U	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101. 00	10100 HOME HEALTH AGENCY	C	ol ol	231	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS		<u> </u>	20.	<u>~</u> 1		
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	C	ol	77	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 841	43, 946	34, 085	104, 993	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	1 1	22	0		192. 00
	07950 FI TNESS CENTER	C		0	0		194. 00
	07951 FOUNDATI ON	C	0	0	0		194. 01
	2 07952 NEW DIRECTION	C	0	0	0		194. 02
	3 O7953 COMMUNITY & VOLUNTEER SERVICES	C		1	0		194. 03
	107956 OTHER NONREIMBURSABLE COST CENTERS			0	0		194. 04 194. 05
200. 00	507955 OCCUPATIONAL HEALTH		ή	ا	Ч		200. 00
200.00	1 1	_		0			200.00
201.00		31, 841	43, 946	34, 108	104, 993		201.00
202.00	TOTAL (Sum TITIES TTO LINGUIGHT 201)	51,041	1 43, 740	34, 100	104, 773	O	1202.00

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

				Fr To	o 12/31/2017 Part II Date/Time Pr 5/29/2018 9:	
	Cost Center Description	Subtotal F	Intern & Residents Cost & Post Stepdown Adjustments	Total	70,27,20.0	
		24. 00	25. 00	26. 00		
GEN	IERAL SERVICE COST CENTERS					
2. 00 002 4. 00 004 5. 00 005 7. 00 007 8. 00 008 9. 00 001 11. 00 011 13. 00 012 14. 00 014 15. 00 018	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 500 OPERATION OF PLANT 300 LAUNDRY & LINEN SERVICE 600 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 500 MEDICAL RECORDS & LIBRARY 601 CAL RECORDS & LIBRARY 602 CATERIA					1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30.00 030	000 ADULTS & PEDIATRICS	289, 710	0	289, 710		30.00
43.00 043	NURSERY	0	0	0		43. 00
ANC	CILLARY SERVICE COST CENTERS					
50.00 050	OOO OPERATING ROOM	166, 294	0	166, 294		50. 00
51. 00 051	100 RECOVERY ROOM	0	0	0		51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0	0	0		52. 00
53. 00 053	BOO ANESTHESI OLOGY	1, 617	0	1, 617		53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	124, 853	O	124, 853		54.00
56. 00 056	600 RADI OI SOTOPE	0	0	0		56. 00
60.00 060	000 LABORATORY	88, 825	o	88, 825		60.00
63. 00 063	BOO BLOOD STORING, PROCESSING & TRANS.	0	o	0		63.00
66. 00 066	500 PHYSI CAL THERAPY	65, 060	0	65, 060		66. 00
1	700 OCCUPATI ONAL THERAPY	5, 791	o	5, 791		67. 00
	BOO SPEECH PATHOLOGY	4, 715	o	4, 715		68. 00
69. 00 069	POO ELECTROCARDI OLOGY	75, 576	o	75, 576		69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 758	o	28, 758		71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	24, 371	o	24, 371		72. 00
	BOO DRUGS CHARGED TO PATIENTS	183, 955	ol	183, 955		73. 00
	TPATIENT SERVICE COST CENTERS	,		,,		
	DOO CLINIC	6, 108	0	6, 108		90.00
	001 SENI OR CARE	27, 246	ol	27, 246		90. 01
	100 EMERGENCY	166, 015	Ö	166, 015		91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART	,	o	,		92. 00
	HER REIMBURSABLE COST CENTERS		-			
	100 HOME HEALTH AGENCY	20, 622	0	20, 622		101. 00
	CCIAL PURPOSE COST CENTERS		-1			
	BOO INTEREST EXPENSE					113. 00
	600 HOSPI CE	9, 523	o	9, 523		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 289, 039	o	1, 289, 039		118. 00
	REI MBURSABLE COST CENTERS	1/20//00/	<u> </u>	1, 20, , 00,		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 835	0	6, 835		190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	106, 123	o	106, 123		192. 00
	950 FITNESS CENTER	32, 992	o	32, 992		194. 00
	951 FOUNDATION	4, 495	o	4, 495		194. 01
	952 NEW DIRECTION	4, 479	0	7, 7,5		194. 02
	953 COMMUNITY & VOLUNTEER SERVICES	4, 002	Ö	4, 002		194. 03
	956 OTHER NONREIMBURSABLE COST CENTERS	8, 787	ol o	8, 787		194. 04
	955 OCCUPATIONAL HEALTH	0, 707	o	0, 707		194. 05
200.00	Cross Foot Adjustments	o	o	0		200. 00
201.00	Negative Cost Centers	o	o	n		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 452, 273	o	1, 452, 273		202. 00
	, (91	, , , , , , , ,		

	•	PARKVIEW WABASH		ON 45 4040 5		u or Form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2017	Worksheet B-1	
					o 12/31/2017	Date/Time Pre	nared:
				'	0 12/01/201/	5/29/2018 9:5	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	'	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
		(,	(,	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(ACCOM: COST)	
				SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	7.00		3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	124, 010	1				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	124,010	1				2. 00
		000	124, 010	1			1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	833	1				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	34, 637	1				
7.00	00700 OPERATION OF PLANT	2, 836	2, 836	247, 640	0	976, 133	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1	,	0	
9.00	00900 HOUSEKEEPI NG	2, 448	2, 448	205, 380	0	502, 518	9. 00
10.00	01000 DI ETARY	4, 959	4, 959	140, 372	0	295, 524	10.00
11.00	01100 CAFETERI A	1, 538		291, 952	0	388, 795	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 107	1	1		508, 085	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 993				26, 357	1
15. 00	01500 PHARMACY	6, 352	1	1	-		
	01600 MEDICAL RECORDS & LIBRARY	0,332		1			1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		,	1	, 0	0	10.00
20.00	03000 ADULTS & PEDIATRICS	12, 406	12, 406	1 072 5/3		2 075 112	20.00
30.00	1		1				
43. 00	04300 NURSERY	0	0	(0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	10.000	10.000				
50. 00	05000 OPERATING ROOM	10, 228	10, 228	532, 443	0		1
51.00	05100 RECOVERY ROOM	0) 0	(0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53.00	05300 ANESTHESI OLOGY	171	171		0	1, 173	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 098	7, 098	800, 100	0	1, 229, 895	54.00
56.00	05600 RADI OI SOTOPE	0	0	(0	0	56.00
60.00	06000 LABORATORY	3, 021	3, 021		0	1, 306, 685	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0,021	1		n n	0	1
66. 00	06600 PHYSI CAL THERAPY	576	1	906, 134		1, 188, 267	1
		370	370				1
67. 00	06700 OCCUPATI ONAL THERAPY	0		77, 767		109, 595	
68. 00	06800 SPEECH PATHOLOGY	0	0	63, 525		89, 525	
69. 00	06900 ELECTROCARDI OLOGY	3, 692	3, 692	542, 456		735, 949	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0) 0	(0	370, 277	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	326, 892	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	1, 787, 378	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	4, 971	0	124, 027	90.00
90. 01	09001 SENI OR CARE	1, 483	1, 483	147, 941	0	288, 312	90. 01
91.00	09100 EMERGENCY	2, 624	2, 624	590, 705	0	2, 564, 520	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		· ·				92.00
	OTHER REIMBURSABLE COST CENTERS		•		1		
101 00	10100 HOME HEALTH AGENCY	906	906	169, 783	0	262, 428	101 00
	SPECIAL PURPOSE COST CENTERS	,,,,	, , , , ,	1077700	,ı	202/ 120	1.000
113 00	11300 NTEREST EXPENSE			1			113. 00
	11600 HOSPI CE	0	0	66, 316		192, 140	1
118.00	1	_	1				1
110.00		101, 900	101, 900	10, 090, 393	-0, 407, 009	17, 400, 703	1110.00
100.00	NONREI MBURSABLE COST CENTERS	000	000	J ,	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	F 201	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	800			70.47		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	15, 519	1		-78, 176		192. 00
	07950 FI TNESS CENTER	3, 862	•	1	0		194. 00
	O7951 FOUNDATI ON	547	1	1	182, 035		194. 01
	07952 NEW DIRECTION	0	1	1	0		194. 02
194. 03	07953 COMMUNITY & VOLUNTEER SERVICES	105		(0	64, 081	194. 03
194.04	07956 OTHER NONREIMBURSABLE COST CENTERS	1, 269	1, 269	(0	8, 377	194. 04
194.05	07955 OCCUPATI ONAL HEALTH	0	0	(0	0	194. 05
200.00	Cross Foot Adjustments						200.00
201.00							201. 00
202.00		304, 776	513, 814	2, 655, 956		8, 467, 809	202.00
	Part I)			, , , , , , ,		., ,	
203.00		2. 457673	4. 143327	0. 262238	3	0. 479944	203.00
204.00				5, 498		864, 075	1
201.00	Part II)			0, 170		001,070	201.00
205.00	1 1 '			0. 000543	8	0. 048975	205 00
200.00				0.000343	1	0.040973	200.00
206.00							206. 00
200.00	(per Wkst. B-2)	'					200.00
207.00							207. 00
50	Parts III and IV)						
		1	•	•	'	•	

	LLOCATION - STATISTICAL BASIS	AKKVIEW WADASH	Provi der Co	°N: 15 1210 E	Peri od:	Workshoot P 1	
CUSTA	LLUCATION - STATISTICAL BASIS		Provider C		rom 01/01/2017	Worksheet B-1	
					o 12/31/2017	Date/Time Pre	pared.
				'	0 12/01/201/	5/29/2018 9:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT			(MEALS SERVED)		
		(SQUARE FEET)	(POUNDS OF	(SQOTINE TEET)	(MENES SERVED)	(1100110)	
		(SQUARE TEET)	LAUNDR)				
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1 00							1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	68, 916					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	10, 000				8. 00
9.00	00900 HOUSEKEEPI NG	2, 448	0	66, 468	3		9. 00
10.00	01000 DI ETARY	4, 959	62	4, 959	20, 693		10.00
11. 00	01100 CAFETERI A	1, 538		1, 538		l	1
	01300 NURSI NG ADMI NI STRATI ON	2, 107		2, 107		475	1
	01400 CENTRAL SERVICES & SUPPLY	3, 993		3, 993		0	1
	01500 PHARMACY						1
15.00		6, 352		6, 352			
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	<u> </u>) 0	0	16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		T	T			
30. 00	03000 ADULTS & PEDIATRICS	12, 406					
43.00	04300 NURSERY	0	0	[0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 228	783	10, 228	0	894	50. 00
51.00	05100 RECOVERY ROOM	0	0	l c	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	o	52. 00
53. 00	05300 ANESTHESI OLOGY	171	0	171	0	Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1, 956				1
		7, 098	1, 930	7,090		1, 456	1
56.00	05600 RADI OI SOTOPE	0 001	0	0.004	0	0	56. 00
60.00	06000 LABORATORY	3, 021	0	3, 021	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	[C	0	0	63. 00
66.00	06600 PHYSI CAL THERAPY	576	0	576	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	80	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	l c	0	87	68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 692	27	3, 692	0	2, 653	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1	١	1	o o		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0			0		73. 00
73.00	OUTPATIENT SERVICE COST CENTERS				, O		73.00
00 00	09000 CLINIC	0	0		0	9	90.00
90.00							
	09001 SENI OR CARE	1, 483		1, 483			
	09100 EMERGENCY	2, 624	3, 126	2, 624	0	1, 080	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	906	0	906	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	0	0	l	0	l 0 ¹	116. 00
118.00		63, 602	9, 837	61, 154	20, 693		118. 00
	NONREI MBURSABLE COST CENTERS					,	
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	800	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	•				192. 00
194.00	07950 FITNESS CENTER	3, 862					194. 00
	07951 FOUNDATI ON	547		J			194. 01
	07952 NEW DIRECTION	0	-	C	1		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	105	0	105	0		194. 03
194.04	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 04
194.05	07955 OCCUPATIONAL HEALTH	0	0	l c	0	0	194. 05
200.00	Cross Foot Adjustments						200. 00
201.00	, ,						201. 00
202.00	1 3	1, 444, 622	0	795, 013	600, 624		
202.00	Part I)	1, 111, 022	Ĭ	7,0,010	000, 02 1	020,001	202.00
203.00		20. 962070	0. 000000	11. 960838	29. 025468	63. 802589	202 00
204.00	**	66, 660		43, 250	55, 308	31, 8411	204. 00
205 25	Part II)	0.017011	0.0000-	0 /50/	0 /	0 0:	205 66
205.00		0. 967264	0. 000000	0. 650689	2. 672788	3. 245108	205.00
		1					
206.00		1					206. 00
	(per Wkst. B-2)]					
207.00	NAHE unit cost multiplier (Wkst. D,	1					207. 00
	Parts III and IV)	[
					•		

Heal th F	Financial Systems F	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider Co		Peri od:	Worksheet B-1	
					From 01/01/2017 o 12/31/2017	Date/Time Pre	nared:
						5/29/2018 9:5	8 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY		
		(DI RECT NRS	(COSTED	REQUIS.)	(GROSS REV)		
		I NG HR)	REQUIS.)		(OKOSS KEV)		
		13. 00	14. 00	15. 00	16.00		
	SENERAL SERVICE COST CENTERS	T T		T			
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	82, 403					11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	02, 403	1, 333, 503				14. 00
	01500 PHARMACY	O	91, 175		2		15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0				16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
1	03000 ADULTS & PEDIATRICS	41, 218	70, 999				30. 00
	04300 NURSERY	0	0		0		43.00
	NCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	18, 651	224, 415	24, 283	3 0		50.00
	05100 RECOVERY ROOM	18, 031	224, 413	24, 203			51.00
	05200 DELIVERY ROOM & LABOR ROOM	O	0				52. 00
	D5300 ANESTHESI OLOGY	o	0	529	0		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	32, 681	973			54.00
	05600 RADI OI SOTOPE	0	0	C			56. 00
1	06000 LABORATORY	0	0				60.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06600 PHYSICAL THERAPY	0	27, 947		-		63. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	o o	2, 030				67. 00
	06800 SPEECH PATHOLOGY	0	0	51			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	11, 112	(0		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	415, 305				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	326, 892		-		72.00
	07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	0	0	329, 735	5 0		73. 00
	99000 CLINIC	T ol	92		0		90.00
	09001 SENI OR CARE	O	526				90. 01
91.00	99100 EMERGENCY	22, 534	117, 381	30	0		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	THER REIMBURSABLE COST CENTERS		0.040	1			101 00
	O100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	9, 048	(0		101. 00
	1300 INTEREST EXPENSE						113. 00
	1600 HOSPI CE	0	2, 994		0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	82, 403	1, 332, 597		0		118. 00
	IONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	868 0				192.00
	07950 FITNESS CENTER 07951 FOUNDATION	0	0	`			194. 00 194. 01
	07952 NEW DIRECTION		0				194. 02
1	07953 COMMUNITY & VOLUNTEER SERVICES	O	38				194. 03
194.040	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0		194. 04
	07955 OCCUPATIONAL HEALTH	0	0	C	0		194. 05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	051 611	170 460	1 706 427	,		201. 00 202. 00
202. 00	Part I)	851, 611	170, 469	1, 706, 427			202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	10. 334709	0. 127835	4. 752590	0. 000000		203. 00
204. 00	Cost to be allocated (per Wkst. B,	43, 946	34, 108				204. 00
0.5-	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 533306	0. 025578	0. 292417	0. 000000		205. 00
206. 00							206. 00
200.00	(per Wkst. B-2)	·					255.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1310	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared:

			Т	o 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 641, 511		4, 641, 511	0	0	00.00
43. 00 04300 NURSERY	0		0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 430, 506		2, 430, 506	0	0	50. 00
51.00 05100 RECOVERY ROOM	0		0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	9, 880		9, 880	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 155, 562		2, 155, 562	0	0	54. 00
56. 00 05600 RADI 0I SOTOPE	0		0	0	0	56. 00
60. 00 06000 LABORATORY	2, 033, 281		2, 033, 281	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	1, 796, 104	0	1, 796, 104	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	168, 689	0	168, 689	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	138, 285	0	138, 285	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 381, 402		1, 381, 402	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	601, 079		601, 079	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	525, 570		525, 570	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 212, 315		4, 212, 315	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	184, 139		184, 139	0	0	90.00
90. 01 09001 SENI OR CARE	492, 167		492, 167	0	0	90. 01
91. 00 09100 EMERGENCY	4, 198, 679		4, 198, 679	0	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 326, 476		1, 326, 476		0	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	419, 365		419, 365		0	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	284, 739		284, 739			116. 00
200.00 Subtotal (see instructions)	26, 999, 749		26, 999, 749	0		200. 00
201.00 Less Observation Beds	1, 326, 476		1, 326, 476			201. 00
202.00 Total (see instructions)	25, 673, 273	0	25, 673, 273	0	0	202. 00

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

	AKKVILW WADASII I			III LIE	u or rorm cws-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 01/01/2017	Part I Date/Time Pre	
				To 12/31/2017	5/29/2018 9:5	
		Ti tl e	e XVIII	Hospi tal	Cost	o am
		Charges	·			
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
·	·	·	+ col. 7)	Ratio	Inpati ent	
			ĺ ,		Rati o	
	6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 532, 591		3, 532, 59	1		30.00
43. 00 04300 NURSERY	0			0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	201, 640	8, 716, 513	8, 918, 15	3 0. 272535	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	C		0. 000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0. 000000	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	34, 575	1, 242, 237	1, 276, 81	2 0. 007738	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 092, 863	25, 325, 207	26, 418, 07	0. 081594	0.000000	54.00
56. 00 05600 RADI OI SOTOPE	0	C		0. 000000	0.000000	56.00
60. 00 06000 LABORATORY	911, 061	10, 642, 325	11, 553, 38	6 0. 175990	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0. 000000	0.000000	63.00
66. 00 06600 PHYSI CAL THERAPY	177, 305	3, 603, 052	3, 780, 35	7 0. 475115	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	110, 516	166, 882	277, 39	8 0. 608112	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	18, 924	62, 783	81, 70	7 1. 692450	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	994, 401	2, 237, 111	3, 231, 51	2 0. 427479	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	80, 053	1, 822, 163	1, 902, 21	6 0. 315989	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	352	1, 771, 148	1, 771, 50	0. 296681	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 629, 542	13, 497, 939	15, 127, 48	1 0. 278454	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	751, 050	751, 05	0. 245175	0. 000000	90.00
90. 01 09001 SENI OR CARE	0	461, 516	461, 51	6 1. 066414	0.000000	90. 01
91. 00 09100 EMERGENCY	397, 850	13, 434, 399	13, 832, 24	9 0. 303543	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 058, 992	1, 058, 99	2 1. 252584	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					Ī
101.00 10100 HOME HEALTH AGENCY	0	165, 297	165, 29	7		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	200, 368	200, 36	8		116.00
200.00 Subtotal (see instructions)	9, 181, 673	85, 158, 982	94, 340, 65	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9, 181, 673	85, 158, 982	94, 340, 65	5		202. 00
			•			•

INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 43.00 A000 ADULTS & PEDIATRICS 43.00 A000 AURSERY 43.00 AURSER
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 30.00 ADULTS & PEDI ATRI CS 43.00 ADULTS & PEDI ATRI CS ADULTS & ADUL
11.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3300 0 ADULTS & PEDI ATRI CS 43.00
30. 00
43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 60. 00
50. 00 05000 OPERATI NG ROOM 0.000000 50.00 51. 00 05100 RECOVERY ROOM 0.000000 51.00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 05300 ANESTHESI OLOGY 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 56.00 60. 00 06400 LABORATORY 0.000000 60.00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 63.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 00TPATI ENT SERVI CE COST CENTERS 0.000000 733.00
51. 00 05100 RECOVERY ROOM 0.000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 60. 00 06000 LABORATORY 0.000000 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 73.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 60. 00 06000 LABORATORY 0.000000 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 73. 00
53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 54. 00 56. 00 05600 RADI OL STOPE 0.000000 56. 00 60. 00 06000 LABORATORY 0.000000 60. 00 63. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 0UTPATI ENT SERVI CE COST CENTERS 0.000000 73. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 60. 00 06000 LABORATORY 0.000000 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 00TPATI ENT SERVI CE COST CENTERS
56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 60. 00 06000 LABORATORY 0.000000 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 000000 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00
60. 00 06000 LABORATORY 0.000000 63. 00 63. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 71. 00 71. 00 72. 00 73. 00 73. 00 000000 0000000 0000000 000000
63. 00
66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0UTPATI ENT SERVICE COST CENTERS 0.000000 73. 00 00 00 00 00 00 00 00
68. 00 06800 SPEECH PATHOLOGY 0.000000 69. 00 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
69. 00 06900 ELECTROCARDI OLOGY 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
73. 00 O7300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 OUTPATIENT SERVICE COST CENTERS
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0. 000000 90. 00
11:11 1:11:1 1:11:11
90. 01 09001 SENI OR CARE 0. 000000 90. 01
91. 00 09100 EMERGENCY 0. 000000 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 000000 92. 00
OTHER REI MBURSABLE COST CENTERS
101. 00 10100 HOME HEALTH AGENCY 101. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
116. 00 11600 HOSPI CE 116. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202. 00 Total (see instructions) 202. 00

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	From 01/01/2017 Pa To 12/31/2017 Da 5,		Worksheet C Part I Date/Time Pre 5/29/2018 9:5	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						5/29/2018 9:50	8 alli
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDI ATRI CS	4, 641, 511		4, 641, 511	0	4, 641, 511	30.00
	04300 NURSERY	0,041,311		1, 041, 311	1	4, 041, 311	1
43.00	ANCI LLARY SERVI CE COST CENTERS				<u> </u>	U	45.00
50. 00	05000 OPERATING ROOM	2, 430, 506		2, 430, 506		2, 430, 506	50.00
51. 00	05100 RECOVERY ROOM	2, 430, 300		2, 430, 300		2, 430, 500	
		0					
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			U	0	
53. 00	05300 ANESTHESI OLOGY	9, 880		9, 880		9, 880	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 155, 562		2, 155, 562	. 0	2, 155, 562	
56.00	05600 RADI OI SOTOPE	0		C	0	0	00.00
60.00	06000 LABORATORY	2, 033, 281		2, 033, 281	0	2, 033, 281	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		C	0	0	00.00
66.00	06600 PHYSI CAL THERAPY	1, 796, 104	0	1, 796, 104	. 0	1, 796, 104	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	168, 689	0	168, 689	0	168, 689	67. 00
68.00	06800 SPEECH PATHOLOGY	138, 285	0	138, 285	0	138, 285	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 381, 402		1, 381, 402	. 0	1, 381, 402	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	601, 079		601, 079	o	601, 079	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	525, 570		525, 570	o	525, 570	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 212, 315		4, 212, 315		4, 212, 315	1
	OUTPATIENT SERVICE COST CENTERS			, , , , , ,			
90.00	09000 CLI NI C	184, 139		184, 139	0	184, 139	90.00
	09001 SENI OR CARE	492, 167		492, 167		492, 167	
	09100 EMERGENCY	4, 198, 679		4, 198, 679		4, 198, 679	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 326, 476		1, 326, 476		1, 326, 476	1
72.00	OTHER REIMBURSABLE COST CENTERS	1, 320, 470		1, 320, 470		1, 320, 470	72.00
101 00	10100 HOME HEALTH AGENCY	419, 365		419, 365		419, 365	101 00
101.00	SPECIAL PURPOSE COST CENTERS	417, 303		417, 300		417, 303	1101.00
112 00	11300 INTEREST EXPENSE						113. 00
		204 720		204 720			
	11600 HOSPI CE	284, 739		284, 739		284, 739	
200.00		26, 999, 749		20, , , , , , , ,		26, 999, 749	
201.00		1, 326, 476		1, 326, 476		1, 326, 476	
202.00	Total (see instructions)	25, 673, 273	0	25, 673, 273	0	25, 673, 273	J202. 00

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

Hearth Financial Systems P	AKKVIEW WABASH F	HUSPITAL, INC.		In Lie	u oi form cws	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre	pared:
-					5/29/2018 9:5	8 am
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati 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						
30. 00 03000 ADULTS & PEDIATRICS	3, 532, 591		3, 532, 59	1		30.00
43. 00 04300 NURSERY	0			0		43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	201, 640	8, 716, 513	8, 918, 15	3 0. 272535	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0. 000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	34, 575	1, 242, 237	1, 276, 81	2 0.007738	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 092, 863	25, 325, 207	26, 418, 07	0. 081594	0.000000	54.00
56. 00 05600 RADI 0I SOTOPE	0	O		0. 000000	0.000000	56.00
60. 00 06000 LABORATORY	911, 061	10, 642, 325	11, 553, 38	6 0. 175990	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	O		0. 000000	0.000000	63.00
66. 00 06600 PHYSI CAL THERAPY	177, 305	3, 603, 052	3, 780, 35	7 0. 475115	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	110, 516	166, 882	277, 39	0. 608112	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	18, 924	62, 783	81, 70	1. 692450	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	994, 401	2, 237, 111	3, 231, 51	2 0. 427479	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	80, 053	1, 822, 163			0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	352	1, 771, 148			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 629, 542	13, 497, 939			0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	751, 050	751, 05	0. 245175	0.000000	90.00
90. 01 09001 SENI OR CARE	0	461, 516	461, 51	6 1. 066414	0.000000	90. 01
91. 00 09100 EMERGENCY	397, 850	13, 434, 399			0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 058, 992			0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS		.,	., .,			
101. 00 10100 HOME HEALTH AGENCY	0	165, 297	165, 29	7		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	o	200, 368	200, 36	8		116. 00
200.00 Subtotal (see instructions)	9, 181, 673	85, 158, 982				200.00
201.00 Less Observation Beds	,,,.,	33, 133, 702	7., 5.5, 66			201. 00
202.00 Total (see instructions)	9, 181, 673	85, 158, 982	94, 340, 65	5		202. 00
202.00 1000 11100 0000)	7, 131, 079	00, 100, 702	1 71,010,00	- i		1232.00

			To 12/31/2017	Date/Time Prepared: 5/29/2018 9:58 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 272535			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 007738			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081594			54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
60. 00 06000 LABORATORY	0. 175990			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
66. 00 06600 PHYSI CAL THERAPY	0. 475115			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 608112			67. 00
68. 00 06800 SPEECH PATHOLOGY	1. 692450			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 427479			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 315989			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 296681			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 278454			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 245175			90.00
90. 01 09001 SENI OR CARE	1. 066414			90. 01
91. 00 09100 EMERGENCY	0. 303543			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1. 252584			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

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

					, ., ., .,	5/29/2018 9:5	8 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 430, 506	166, 294	2, 264, 212	0	0	00.00
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	9, 880	1, 617	8, 263	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 155, 562	124, 853	2, 030, 709	0	0	54. 00
56.00	05600 RADI OI SOTOPE	o	0	0	0	0	56.00
60.00	06000 LABORATORY	2, 033, 281	88, 825	1, 944, 456	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0	0	0	63. 00
66.00	06600 PHYSI CAL THERAPY	1, 796, 104	65, 060	1, 731, 044	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	168, 689	5, 791		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	138, 285	4, 715	133, 570	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 381, 402	75, 576	1, 305, 826	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	601, 079	28, 758	572, 321	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	525, 570	24, 371	501, 199	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 212, 315	183, 955	4, 028, 360	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	184, 139	6, 108	178, 031	0	0	90.00
90. 01	09001 SENI OR CARE	492, 167	27, 246	464, 921	0	0	90. 01
91.00	09100 EMERGENCY	4, 198, 679	166, 015	4, 032, 664	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 326, 476	82, 795	1, 243, 681	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					'	
101.00	10100 HOME HEALTH AGENCY	419, 365	20, 622	398, 743	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	·			<u> </u>	
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	284, 739	9, 523	275, 216	0	0	116. 00
200.00		22, 358, 238			0	0	200.00
201.00	, , , , , , , , , , , , , , , , , , , ,	1, 326, 476	82, 795	1 ' '	0		201.00
202.00	l	21, 031, 762			0		202. 00
	' ' '		•			•	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 9:58 am

Title XIX			T: ±1	- VIV	11	DDC	o um
Capit fall and Operating Cost Part I		1 2			ноѕрі таі	PP5	
Operating Cost Reduction Ratio (col. 6 Reduction Ratio (col. 6 Reduction Ratio (col. 7)	Cost Center Description						
Reducti on 8)							
ANCI LLARY SERVI CE COST CENTERS 50.00 50000 OPERATI NG ROOM 2, 430, 506 8, 918, 153 0. 272535 50.00 51.00 51.00 05000 OPERATI NG ROOM 0 0 0.000000 51.00 05000 OPERATI NG ROOM 0 0 0.000000 52.00 52.00 OPERATI NG ROOM 0 0 0.0000000 0.0000000 54.00 OPERATI NG ROOM 0 0.00000000							
ANCI LLARY SERVI CE COST CENTERS 50.00							
SO .00	ANCILLARY CERVICE COCT CENTERS	6.00	7.00	8.00			
51.00 05100 RECOVERY ROOM COUNTY ROO		2 420 504	0.010.153	0.272525			F0 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		2, 430, 506	8, 918, 153				
53. 00 05300 ANESTHESI OLOGY 9,880 1,276,812 0.007738 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2,155,562 26,418,070 0.081594 54. 00 60. 00 06000 LABORATORY 2,033,281 11,553,386 0.175990 60. 00 63. 00 06300 BLOD STORI NG, PROCESSI NG & TRANS. 0 0.000000 63. 00 66. 00 06600 PHYSI CAL THERAPY 1,796,104 3,780,357 0.475115 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 188,689 277,398 0.608112 67,00 68. 00 06800 SPEECH PATHOLOGY 138,285 81,707 1.692450 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,381,402 3,231,512 0.427479 69,00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 601,079 1,902,216 0.31599 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 525,570 1,771,500 0.296681 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4,212,315 15,127,481 0.278454 73. 00 70. 00 09000 CLINIC 184,139 751,050 0.245175 90. 01 70. 00 09000 CLINIC 184,139 751,050 0.245175 90. 01 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679 13,832,249 0.303543 91. 00 70. 00 09000 DRERGENCY 4,198,679		0	0				
54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 155, 562 20, 418, 070 0. 081594 54.00 56.00 05600 RADI OI SOTOPE 0 0. 000000 56.00 60.00 06000 LABORATORY 2, 033, 281 11, 553, 386 0. 175990 66.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0. 000000 0. 000000 63.00 66.00 06600 PHYSI CAL THERAPY 1, 796, 104 3, 780, 357 0. 475115 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 86, 689 277, 398 0. 608112 67.00 68.00 06800 SPEECH PATHOLOGY 138, 285 81, 707 1. 692450 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 381, 402 3, 231, 512 0. 427479 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 525, 570 1, 771, 500 0. 315989 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 525, 570 1, 771, 500 0. 296681 72.00 73.00 DUTBATI ENT SERVI CE COST CENTERS 90.01 <td></td> <td>0 000</td> <td>1 27/ 012</td> <td></td> <td></td> <td></td> <td></td>		0 000	1 27/ 012				
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0							
60. 00 06000 LABORATORY 2, 033, 281 11, 553, 386 0. 175990 60. 00 63. 00 63. 00 63. 00 60.		2, 155, 562					
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		2 022 201					
66. 00 06600 PHYSI CAL THERAPY 1,796,104 3,780,357 0.475115 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 168,689 277,398 0.608112 67. 00 68. 00 06900 SPECH PATHOLOGY 138,285 81,707 1.692450 68. 00 06900 ELECTROCARDI OLOGY 1,381,402 3,231,512 0.427479 69. 00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 601,079 1,902,216 0.315989 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 525,570 1,771,500 0.296681 72. 00 07300 DRUGS CHARGED TO PATI ENTS 4,212,315 15,127,481 0.278454 73. 00 09000 CLI NI C 184,139 751,050 0.245175 90. 00 09001 SENI OR CARE 492,167 461,516 1.066414 90. 01 91. 00 09100 EMERGENCY 4,198,679 13,832,249 0.303543 91. 00 09100 BMERGENCY 4,198,679 13,832,249 0.303543 91. 00 07100 BMERGENCY 41,98,679 41,98,679 41,98,679 41,088,992		2, 033, 281	11, 553, 386				
67. 00		4 70/ 404	0 700 057				
68. 00							
69. 00							
71. 00							
72. 00							
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 212, 315 15, 127, 481 0. 278454 73. 00 00000 0000 00000 0000 00000 0000 00000 0000 00000 00000 00000							
OUTPATIENT SERVICE COST CENTERS O90.00 O9000 CLINIC SENIOR CARE O90.00 O9000 CLINIC O9000 O9000 SENIOR CARE O90.00 O9000 O9000 SENIOR CARE O90.00 O9100 EMERGENCY O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART O9100 O9200 O9200 OBSERVATION BEDS (NON-DISTINCT PART O9100							
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 90. 01 90. 00 90. 01 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90		4, 212, 315	15, 127, 481	0. 278454			73.00
90. 01			1	1			
91. 00 09100 EMERGENCY 4, 198, 679 13, 832, 249 0. 303543 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 326, 476 1, 058, 992 1. 252584 92. 00 OTHER REI MBURSABLE COST CENTERS 101.00 OTHER REI MBURSABLE COST CENTERS 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11600 HOSPI CE 284, 739 200, 368 1. 421080 116. 00 200. 00 Subtotal (sum of lines 50 thru 199) 22, 358, 238 90, 808, 064 200. 00 201. 00 Less Observation Beds 1, 326, 476 0 201. 00 2							
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 1, 326, 476 1, 058, 992 1.252584 92. 00 0THER REIMBURSABLE COST CENTERS 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 284, 739 200, 368 1. 421080 116. 00 200. 00 Subtotal (sum of lines 50 thru 199) 22, 358, 238 90, 808, 064 200. 00 Color of Less Observation Beds 1, 326, 476 0 201. 00							
OTHER REIMBURSABLE COST CENTERS 101.00							
101.00 10100 HOME HEALTH AGENCY 419, 365 165, 297 2.537039 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 284, 739 200, 368 1.421080 116.00 116.00 116.00 Subtotal (sum of lines 50 thru 199) 22, 358, 238 90, 808, 064 200.00 201.00 Less Observation Beds 1, 326, 476 0 201.00		1, 326, 476	1, 058, 992	1. 252584			92. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 11421080 116.00 116.							
113.00		419, 365	165, 297	2. 537039			101. 00
116.00 11600 HOSPICE 284,739 200,368 1.421080 200.00 Subtotal (sum of lines 50 thru 199) 22,358,238 90,808,064 200.00 201.00 Less Observation Beds 1,326,476 0 201.00							
200. 00 Subtotal (sum of lines 50 thru 199) 22,358,238 90,808,064 200.00 201. 00 Less Observation Beds 1,326,476 0 201.00							
201.00 Less Observation Beds 1,326,476 0 201.00							
	, ,	22, 358, 238	90, 808, 064				
202.00 Total (line 200 minus line 201) 21,031,762 90,808,064 202.00	201.00 Less Observation Beds	1, 326, 476	0				
	202.00 Total (line 200 minus line 201)	21, 031, 762	90, 808, 064				202. 00

Health Financial Syste	ms PARKVIEW WABASH H	OSPI TAL,	I NC.	In Lie	u of Form CMS-2552-10
ADDODEL ON MENT OF LANDAS	THE ANGLE AND CENTRAL COOPS				W 1 1 1 D

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	166, 294	8, 918, 153			1, 157	
51. 00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 617		•			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	124, 853		1		•	
56. 00 05600 RADI 01 SOTOPE	0		0.00000		0	56.00
60. 00 06000 LABORATORY	88, 825					
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.00000		0	63. 00
66. 00 06600 PHYSI CAL THERAPY	65, 060					1
67. 00 06700 OCCUPATI ONAL THERAPY	5, 791		1			
68. 00 06800 SPEECH PATHOLOGY	4, 715		1			
69. 00 06900 ELECTROCARDI OLOGY	75, 576		1			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	28, 758		•			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	24, 371		•			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	183, 955	15, 127, 481	0. 01216	739, 905	8, 997	73. 00
OUTPATIENT SERVICE COST CENTERS				_	_	
90. 00 09000 CLI NI C	6, 108		•		0	90.00
90. 01 09001 SENI OR CARE	27, 246				0	90. 01
91. 00 09100 EMERGENCY	166, 015					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	82, 795		1		0	, ,
200.00 Total (lines 50 through 199)	1, 051, 979	90, 442, 399	ή	2, 227, 323	29, 457	J200. 00

THROUGH COSTS

					5/29/2018 9:5	8 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	56. 00
60. 00 06000 LABORATORY	0	0		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09001 SENI OR CARE	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			C	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 (C	0	200. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D

From 01/01/2017 | Part IV To 12/31/2017 | Date/Time Prepared: THROUGH COSTS 5/29/2018 9:58 am Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Outpati ent (from Wkst. C, Medi cal (sum of col 1 Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 8, 918, 153 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 51. 00 | 05100 | RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 1, 276, 812 0.000000 53.00 OI 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 26, 418, 070 0.000000 54.00 0 56.00 05600 RADI 0I S0T0PE 0 0.000000 56.00 60.00 06000 LABORATORY 11, 553, 386 0.000000 60.00 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 06600 PHYSI CAL THERAPY 0 0 3, 780, 357 66.00 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 277, 398 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 81, 707 68.00 0 06900 ELECTROCARDI OLOGY 3, 231, 512 0.000000 69 00 69 00 Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1, 902, 216 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 771, 500 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 15, 127, 481 0.000000 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 751, 050 0.000000 90.00 90. 01 09001 SENI OR CARE 0 0 0 0 0 0 0 461, 516 0.000000 90.01 91. 00 09100 EMERGENCY 0 0. 000000 13, 832, 249 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 0 1, 058, 992 0.000000 92.00

90, 442, 399

200. 00

Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1310 Peri od: From 01/01/2017 Part IV Date/Time Prepared: 5/29/2018 9:58 am	Heal th	Financial Systems P.	ARKVIEW WABASH F	IOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
Cost Center Description	APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS			From 01/01/2017	Part IV Date/Time Pre	pared: 8 am
Ratio of Cost to Charges				Title	XVIII	Hospi tal	Cost	
Costs (col. 8 Costs (col. 9 x col. 12)		Cost Center Description	Ratio of Cost	Program	Program	Program	Program	
7) x col. 10) x col. 12)				J				
ANCI LLARY SERVI CE COST CENTERS								
50. 00 05000 OPERATI NG ROOM 0.000000 62,072 0 0 0 50.00 51. 00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 51.00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 0 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 0.000000 7,190 0 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 387,363 0 0 0 54.00 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 0 54.00 60. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 0 0 55.00 60. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			9.00	10.00	11.00	12.00	13.00	
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 7,190 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 387,363 0 0 0 0 54.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 0 56.00 60.00 06000 LABORATORY 0.000000 367,445 0		ANCILLARY SERVICE COST CENTERS						
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0.000000 7, 190 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 387, 363 0 0 0 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0.000000 367, 445 0 0 0 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 0 60. 00 64. 00 06600 PHYSI CAL THERAPY 0.000000 93, 148 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 57, 192 0 0 0 66. 00 69. 00 O6800 SPEECH PATHOLOGY 0.00000 8, 308 0 </td <td>50.00</td> <td>05000 OPERATING ROOM</td> <td>0. 000000</td> <td>62, 072</td> <td></td> <td>0</td> <td>0</td> <td>50.00</td>	50.00	05000 OPERATING ROOM	0. 000000	62, 072		0	0	50.00
53. 00 05300 ANESTHESI OLOGY 0.000000 7, 190 0 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 387, 363 0 0 0 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0.000000 367, 445 0 0 0 0 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 93, 148 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 57, 192 0 0 0 67. 00 68. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 8, 308 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000	51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 387, 363 0 0 0 54. 00 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0.000000 367, 445 0 0 0 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 93, 148 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 57, 192 0 0 0 66. 00 68. 00 0800 SPEECH PATHOLOGY 0.000000 8, 308 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 452, 394 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 49, 338 0 0 0 0 71. 00 72. 00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0.000000 367, 445 0 0 0 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 0 63. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 93, 148 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 57, 192 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 8, 308 0 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 452, 394 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 49, 338 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 122 0 0 0 72. 00	53.00	05300 ANESTHESI OLOGY	0. 000000	7, 190		0 0	0	53.00
60. 00 06000 LABORATORY 0.000000 367, 445 0 0 0 0 60. 00 63. 00 64. 00 65.	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	387, 363		0 0	0	54.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 0 63. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 68. 00 6800 SPEECH PATHOLOGY 0.000000 8, 308 0 0 0 68. 00 69. 00 69. 00 67. 00 67. 00 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 122 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 122 0 0 0 72. 00 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	56.00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 93, 148 0 0 0 66. 00 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 57, 192 0 0 0 67. 00 68. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 8, 308 0 0 0 68. 00 69. 00 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 000000 49, 338 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 122 0 0 0 72. 00 0 72. 00 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	0. 000000	367, 445		0 0	0	60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 57, 192 0 0 0 67. 00 68. 00 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 452, 394 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 122 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 122 0 0 0 72. 00 072. 00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
68. 00 06800 SPEECH PATHOLOGY 0. 000000 8, 308 0 0 0 68. 00 69. 00 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 49, 338 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 122 0 0 0 72. 00 0 72. 00 0 0 0 0 0 0 0 0 0	66.00	06600 PHYSI CAL THERAPY	0. 000000	93, 148		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 452, 394 0 0 69. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 00	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	57, 192		0 0	0	67. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 000000 49, 338 0 0 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 000000 122 0 0 72. 00 72. 00 0 72. 00 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	0. 000000	8, 308		0 0	0	68. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 122 0 0 0 72.00	69.00	06900 ELECTROCARDI OLOGY	0. 000000	452, 394		0 0	0	69. 00
	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	49, 338		0 0	0	71. 00
73.00 <u>07300 DRUGS CHARGED TO PATIENTS</u> <u>0.000000</u> <u>739,905</u> <u>0</u> <u>0</u> 73.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	122		0 0	0	72. 00
CUITDATI FUT OFFICE COOT OFFITEDS	73.00		0. 000000	739, 905		0 0	0	73. 00

0. 000000

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2, 846

2, 227, 323

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0 92.00

90. 01 91. 00

0 200. 00

09000 CLI NI C

90. 01 | 09001 | SENI OR CARE

91. 00 09100 EMERGENCY

90.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

Health Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 9:5	epared:
		Titl∈	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS		1				
50. 00	0. 272535		2, 089, 10	0	0	
51. 00 05100 RECOVERY ROOM	0. 000000)	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000)	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 007738		295, 01		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081594		7, 813, 24	8 0	0	1
56. 00 05600 RADI 01 SOTOPE	0. 000000)	0	0	
60. 00 06000 LABORATORY	0. 175990		3, 825, 41	6 0	0	1 00.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000)	0	0	1 00.00
66. 00 06600 PHYSI CAL THERAPY	0. 475115		1, 225, 73		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 608112		66, 98		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	1. 692450		22, 08		0	1 00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 427479		556, 94		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 315989	0	323, 99		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 296681	0	507, 94		0	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 278454	0	5, 099, 52	25 0	0	73. 00
OUTPATIENT SERVICE COST CENTERS	T	T _				
90. 00 09000 CLI NI C	0. 245175		1	0		
90. 01 09001 SENI OR CARE	1. 066414		327, 34		0	
91. 00 09100 EMERGENCY	0. 303543		3, 449, 74		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 252584	0	493, 09		0	
200.00 Subtotal (see instructions)		0	26, 096, 17	0 (8	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201. 00
202.00 Net Charges (line 200 - line 201)		[o	26, 096, 17	78 0	0	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet D
From 01/01/2017 Part V Provider CCN: 15-1310

				To 12/31/2017	Part V Date/Time Pro 5/29/2018 9:	epared: 58 am
		Title	XVIII	Hospi tal	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANOLILARY OFRIGOR COOT OFFITTED	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	F (0 0 F 4		ı			
50. 00 05000 OPERATING ROOM	569, 354	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2 202	0				52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 283	0				53. 00 54. 00
	637, 514	0				
56. 00 05600 RADI OI SOTOPE	(72 225	0				56. 00
60. 00 06000 LABORATORY	673, 235	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	502.244	0				63. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	582, 366	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	40, 733	0				67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	37, 373	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	238, 081	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	102, 378 150, 697	0				71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	1, 419, 983	0				73. 00
OUTPATIENT SERVICE COST CENTERS	1, 419, 903					73.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 SENI OR CARE	349, 085	0				90.00
91. 00 09100 EMERGENCY	1, 047, 147	0				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	617, 648	0				92.00
200.00 Subtotal (see instructions)	6, 467, 877	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 407, 077	0				201. 00
Only Charges	1					[-51.00
202.00 Net Charges (line 200 - line 201)	6, 467, 877	0				202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ŭ	1			,

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVILORS AND MAGOLINE COST	D ' I OON 45 4040	D 1 1	W I I I D

Period: From 01/01/2017 To 12/31/2017 Worksheet D Part V APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1310 Component CCN: 15-Z310 Date/Time Prepared: 5/29/2018 9:58 am Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 272535 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.007738 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.081594 0 54.00 0 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 0 0 06000 LABORATORY 0 60.00 0.175990 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 06600 PHYSI CAL THERAPY 0. 475115 0 66.00 0 66.00 0 06700 OCCUPATIONAL THERAPY 67 00 67 00 0.608112 0 68.00 06800 SPEECH PATHOLOGY 1.692450 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 427479 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.315989 0 0 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 0.296681 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 278454 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 245175 0 0 0 90.00 00000 0 90.01 09001 SENI OR CARE 1.066414 90.01 0 0 0 91.00 09100 EMERGENCY 0.303543 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 252584 0 0 92.00 92.00 0 Subtotal (see instructions) 0 200.00 0 0 200, 00 0 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00

		,	CCN: 15-Z310		Part V Date/Time Pre 5/29/2018 9:5	
			XVIII	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM			\			50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0				52.00
53. 00 05300 ANESTHESI OLOGY						53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C						54.00
56. 00 05600 RADI OLOGI - DI AGNOSTI C						56.00
60. 00 06000 LABORATORY	0	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0				71.00
72.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			1			73. 00
OUTPATIENT SERVICE COST CENTERS] 0		<u>'</u>			73.00
90. 00 09000 CLINIC	1 0	0				90.00
90. 01 09001 SENI OR CARE	0					90. 01
91. 00 09100 EMERGENCY	0	٥				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	٥				92. 00
200.00 Subtotal (see instructions)	0	١				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	Ĭ				201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202. 00
1 3 (===	1		1			1

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	F	Period: From 01/01/2017 Fo 12/31/2017		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col. 1 - col. 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	289, 710	2, 539	287, 17	1 2, 488	115. 42	30. 00
43. 00 NURSERY	0		(0	0.00	43. 00
200.00 Total (lines 30 through 199)	289, 710		287, 17	1 2, 488		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	28	3, 232				30. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	28	3. 232				200.00

Health Financial Syste	ms PARKVIEW WABASH H	OSPI TAL,	I NC.	In Lie	u of Form CMS-2552-10
ADDODEL ON MENT OF LANDAS	THE ANGLE AND CENTRAL COOPS				W 1 1 1 D

Heal th	Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTI	ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2017 To 12/31/2017		
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATI NG ROOM	166, 294	8, 918, 153				
	05100 RECOVERY ROOM	0	0	0. 00000		0	01.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52. 00
	05300 ANESTHESI OLOGY	1, 617				0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	124, 853	26, 418, 070				
	05600 RADI OI SOTOPE	0	0	0. 00000		0	56. 00
	06000 LABORATORY	88, 825	11, 553, 386				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	63. 00
	06600 PHYSI CAL THERAPY	65, 060					66. 00
	06700 OCCUPATI ONAL THERAPY	5, 791					
	06800 SPEECH PATHOLOGY	4, 715				0	00.00
	06900 ELECTROCARDI OLOGY	75, 576					
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 758			· ·		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 371				0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	183, 955	15, 127, 481	0. 01216	0 29, 310	356	73. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLI NI C	6, 108				0	70.00
	09001 SENI OR CARE	27, 246				0	90. 01
1	09100 EMERGENCY	166, 015				170	
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	82, 989		•		0	92. 00
200. 00	Total (lines 50 through 199)	1, 052, 173	90, 442, 399		110, 800	1, 256	200. 00

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 8 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments	Ü	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	
43. 00 04300 NURSERY	0	0	1	0	0	43. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 48			
43. 00 04300 NURSERY		0		0.00		
200.00 Total (lines 30 through 199)		0	2, 48	8	28	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)						200. 00
200.00 10tal (11103 30 till dagil 177)	ı					1200.00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

THROUGH COSTS 12/31/2017 Date/Time Prepared: To 5/29/2018 9:58 am Title XIX Hospi tal Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Post-Stepdown Anesthetist Post-Stepdown Cost Adjustments Adjustments 3.00 1.00 2.00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53. 00 | 05300 | ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 05600 RADI OI SOTOPE 0 56.00 56.00 0 60.00 06000 LABORATORY 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 Ω 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 0 71.00 0 71.00 0 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 0 0 90.00 0 0 0 0 0 0 90. 01 09001 SENI OR CARE 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 200. 00 200.00 Total (lines 50 through 199)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D

From 01/01/2017 | Part IV To 12/31/2017 | Date/Time Prepared: THROUGH COSTS 5/29/2018 9:58 am Title XIX Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges (sum of col 1 Outpati ent (from Wkst. C, Medi cal Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col 8) col. 2, 3 and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 8, 918, 153 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 51. 00 | 05100 | RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 1, 276, 812 0.000000 53.00 OI 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 26, 418, 070 0.000000 54.00 0 56.00 05600 RADI 0I S0T0PE 0 0.000000 56.00 60.00 06000 LABORATORY 11, 553, 386 0.000000 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63 00 06600 PHYSI CAL THERAPY 0 0 3, 780, 357 66.00 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 277, 398 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 81, 707 68.00 0 06900 ELECTROCARDI OLOGY 3, 231, 512 0.000000 69 00 69 00 Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1, 902, 216 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 771, 500 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 15, 127, 481 0.000000 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 751, 050 0.000000 90.00 90. 01 09001 SENI OR CARE 0 0 0 0 0 0 0 461, 516 0.000000 90.01 91. 00 09100 EMERGENCY 0 0. 000000 13, 832, 249 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 0 1, 058, 992 0.000000 92.00 Total (lines 50 through 199) 90, 442, 399 200. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.			eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1310	From 01/01/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 9:58 am
		Title XIX	Hospi tal	PPS
Cost Center Description	Outpati ent	Inpatient Inpatie	nt Outpatient	Outpatient

			10	12/31/2017	Date/lime Prep 5/29/2018 9:58	
-		Ti tl	e XIX	Hospi tal	PPS	o am
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	·	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	2, 775	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	24, 270	0	0	0	54. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000	0	0	0	0	56. 00
60. 00 06000 LABORATORY	0. 000000	22, 602	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 335	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	502	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	14, 052	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 792	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	29, 310	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	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	14, 162	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92. 00
200.00 Total (lines 50 through 199)		110, 800	0	0	0	200. 00

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	0.070505			07.045		
50. 00 05000 OPERATING ROOM	0. 272535		1	0 27, 845	0	
51. 00 05100 RECOVERY ROOM	0. 000000		1	0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000		1	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 007738	l .	1	0 2, 416	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 081594	l .	1	0 285, 014	0	
56. 00 05600 RADI OI SOTOPE	0. 000000		1	0	0	
60. 00 06000 LABORATORY	0. 175990	l .	1	0 210, 856	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		1	0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 475115		1	0 31, 837	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 608112	l e	1	0 0	0	
68. 00 06800 SPEECH PATHOLOGY	1. 692450	l e		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 427479			0 6, 555	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 315989	0		0 33, 134	0	,
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 296681	0		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 278454	0		0 216, 894	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 245175	l e		0 0	0	
90. 01 09001 SENI OR CARE	1. 066414			0 0	0	
91. 00 09100 EMERGENCY	0. 303543	0	1	0 240, 463	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 252584	0	1	0 32, 476	0	
200.00 Subtotal (see instructions)		0	1	0 1, 087, 490	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1	0 1, 087, 490	0	202. 00

Provider CCN: 15-1310

			1	Го 12/31/2017	Date/Time Prepared: 5/29/2018 9:58 am	1:
		Ti tl	e XIX	Hospi tal	PPS	_
	Co:	sts		· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
, and the second	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0	7, 589			50.0	
51.00 05100 RECOVERY ROOM	0	0			51.0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 0	
53. 00 05300 ANESTHESI OLOGY	0	19			53. 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	23, 255			54.0	
56. 00 05600 RADI 0I SOTOPE	0	0			56.0	00
60. 00 06000 LABORATORY	0	37, 109			60.0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.0	
66. 00 06600 PHYSI CAL THERAPY	0	15, 126			66. 0	00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			67. 0	00
68. 00 06800 SPEECH PATHOLOGY	0	0			68.0	00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 802			69. 0	DO
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 470			71.0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 0	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	60, 395			73. 0	00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0			90.0	
90. 01 09001 SENI OR CARE	0	0			90.0	D1
91. 00 09100 EMERGENCY	0	72, 991			91. 0	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	40, 679			92. 0	00
200.00 Subtotal (see instructions)	0	270, 435			200. 0	00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 0	00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	270, 435			202. 0	00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Prepared: 5/29/2018 9:58 am	
'	Title XVIII	Hospi tal	Cost	

		Title XVIII	Hospi tal	5/29/2018 9:5 Cost	8 am
	Cost Center Description	THE AVIII	1103pi tui	0031	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 589	1. 00
2.00	Inpatient days (including private room days, excluding swing-k	ped and newborn days)		2, 488 0	2. 00 3. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.				
4. 00					4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	31 of the cost	1, 769 22	5. 00	
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	79	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	860	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	22	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar ye				
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed of	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
40.00	reporting period			407.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	137. 32	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	after December 31 of the	ne cost	137. 32	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		4, 641, 511	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a ported (line 4	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Title 6	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	10, 848	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	J			
26. 00 27. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		51, 436 4, 590, 075	
27.00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	TTHE 21 IIITHUS TTHE 20)		4, 590, 075	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	- Tine 28)		0.00000	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir	ous line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x lin		1 0113)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 590, 075	37. 00
	27 minus line 36)	,		., ,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 044 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 844. 89 1, 586, 605	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra			1, 566, 605	40.00
41. 00		•		1, 586, 605	
			·		

	Financial Systems ATION OF INPATIENT OPERATING COST	PARKVIEW WABASH I		CN: 15-1310	Peri od:	wof Form CMS-2 Worksheet D-1	
017	or			5 .510	From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
			Ti tl e	e XVIII	Hospi tal	Cost	o am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days	col. 2	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only)	0	C	0.	00 0	0	42.
	Intensive Care Type Inpatient Hospital Uni	ts					42
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 44.
	BURN INTENSIVE CARE UNIT						45.
1	SURGICAL INTENSIVE CARE UNIT						46.
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3	, line 200)			622, 251	48.
	Total Program inpatient costs (sum of line	s 41 through 48)(see instructio	ons)		2, 208, 856	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program i	nnationt routing	convices (from	Wkst D su	m of Dorte L and	0	50.
0.00	III)	iipatreiit routriie	services (IIIII	II WKSt. D, Su	III OI PAILS I AIIU	0	50.
1. 00	Pass through costs applicable to Program i	npatient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.
	and IV)	- 50 54				_	
	Total Program inpatient operating cost evo		lated non-nhy	sician anest	hetist and	0	
	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					Ĭ	55.
	TARGET AMOUNT AND LIMIT COMPUTATION	·					
	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	1
- 1	Difference between adjusted inpatient oper	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	1
	Bonus payment (see instructions)					0	
	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.
						0.00	60.
1. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by				0	61.	
	which operating costs (line 53) are less t		s (lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (se Relief payment (see instructions)	e mstructions)				0	62.
3.00	Allowable Inpatient cost plus incentive pa	yment (see instru	ctions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST	+b	21 -6 +1-		l	40 500	
4. 00	Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through bece	iiber 31 01 the	e cost report	ing period (see	40, 588	64.
	Medicare swing-bed SNF inpatient routine of	osts after Decemb	er 31 of the d	cost reportin	g period (See	0	65.
	instructions)(title XVIII only)	(1:	/	· E	III)	40 500	,,
6. 00	Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	itine costs (line	54 plus line 6	ob)(title XVI	II only). For	40, 588	66.
7. 00	Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 d	of the cost r	eporting period	0	67.
	(line 12 x line 19)					_	
8. 00	Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after D	ecember 31 of	the cost rep	orting period	0	68.
9. 00	Total title V or XIX swing-bed NF inpatien	t routine costs (line 67 + line	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER						
	Skilled nursing facility/other nursing fac)		70.
1	Adjusted general inpatient routine service Program routine service cost (line 9 x lin		ine 70 ÷ iine	2)			71. 72.
	Medically necessary private room cost appl		(line 14 x li	ne 35)			73.
	Total Program general inpatient routine se						74.
5. 00	Capital-related cost allocated to inpatien 26, line 45)	t routine service	costs (from V	Worksheet B,	Part II, column		75.
6. 00	Per diem capital-related costs (line 75 ÷	line 2)					76.
- 1	Program capital-related costs (line 9 x li	,					77.
- 1	Inpatient routine service cost (line 74 mi		noud down	do)			78.
1	Aggregate charges to beneficiaries for exc Total Program routine service costs for co			*.	nus line 79)		79. 80.
1	Inpatient routine service cost per diem li	•	oot iim tati oi	. (11110 /0 11111	11110 777		81.
2. 00	Inpatient routine service cost limitation	(line 9 x line 81					82
1	Reasonable inpatient routine service costs		s)				83.
	Program inpatient ancillary services (see Utilization review - physician compensation		ns)				84.
	Total Program inpatient operating costs (s						86.
]	PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST					
7.00	Total observation bed days (see instruction		0)			719 1, 844. 89	87. 88.
	Adjusted general inpatient routine cost pe						

Health Financial Systems Pa	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Prep 5/29/2018 9:58	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	289, 710	4, 641, 511	0. 06241	7 1, 326, 476	82, 795	90. 00
91.00 Nursing School cost	0	4, 641, 511	0.00000	1, 326, 476	0	91.00
92.00 Allied health cost	0	4, 641, 511	0.00000	1, 326, 476	0	92. 00
93.00 All other Medical Education	o	4, 641, 511	0. 00000	1, 326, 476	0	93. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2017	Worksheet D-1
			Date/Time Prepared: 5/29/2018 9:58 am
	Title XIX	Hospi tal	PPS

2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Sing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medical reperiod 18.00 Medicald rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Med	am
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days. excluding newborn) 2.589 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 2.488 2.488 3.00 Private room days (excluding swing-bed and observation bed days) 1.769 3.00 3.00 2.488 3.00	
INPATIENT DAYS	
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17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 10 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20 0.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	6. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20	
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20	7. 00
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20	8. 00
reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20	
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20	9. 00
reporting period	0. 00
reporting period	
	1. 00 2. 00
5 x line 17)	2.00
	3. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24 24 24 24 24 24 24	4. 00
7 x line 19)	4.00
	5. 00
x line 20) 26.00 Total swing-bed cost (see instructions) 40,683 20	6. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4,600,828 2	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
	8. 00 9. 00
	0.00
	1. 00
	2. 00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 3:	3. 00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 3	4. 00
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 39	5. 00
	6. 00
	7. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
	8. 00
	9. 00
	0. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	1. 00

	Financial Systems P. ATION OF INPATIENT OPERATING COST	ARKVIEW WABASH I		CN: 15-1310	In Lie	worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1310	From 01/01/2017 To 12/31/2017		pared:
			Ti tl	le XIX	Hospi tal	PPS	o alli
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Person (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	Lupasay (d. d. d	1.00	2. 00	3.00	4.00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					26, 686	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		78, 464	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fror	m Wkst. D, su	m of Parts I and	3, 232	50.00
E1 00	Description of the program in	ationt and		com Wico+ D	cum of Dont- !!	4.054	E1 ~
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (fi	ull WKST. D,	Sum of Parts II	1, 256	51.00
52.00	Total Program excludable cost (sum of lines					4, 488	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rated, non-phy	ysıcıan anest	netist, and	73, 976	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	
58. 00 59. 00						0.00	
37.00	market basket					0.00	37.0
60. 00 61. 00						0.00	1
01.00	which operating costs (line 53) are less that				,		01.0
(2.00	amount (line 56), otherwise enter zero (see instructions)						(2.0)
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reportin	g period (See	0	65. 0
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line 6	55)(title XVI	II only) For	0	66. 0
00.00	CAH (see instructions)		•				
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00	
U 7. UU	PART III - SKILLED NURSING FACILITY, OTHER N					<u> </u>	37.0
70.00	Skilled nursing facility/other nursing facil				")		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /o ÷ iine	۷)			71. 0
73. 00	Medically necessary private room cost applic	abĺe to Program					73. 0
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 0
	26, line 45)		2000 (110111		. 2. 2 . 1 , 301 411111		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
77. 00 78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p					79. 0
30. 00 31. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost IImitation	n (line 78 mi	nus line 79)		80.0
31.00	Inpatient routine service cost limitation ()				82. 0
33.00	Reasonable inpatient routine service costs (s)				83. 0
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 0 85. 0
86. 00	Total Program inpatient operating costs (sum	of lines 83 th	,				86. 0
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					719	87. 0
88. 00	· · · · · · · · · · · · · · · · · · ·		line 2)			1, 849. 21	
	Observation bed cost (line 87 x line 88) (se	o instructions)				1, 329, 582	1 89 0

Health Financial Systems Pa	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Prep 5/29/2018 9:58	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	289, 710	4, 641, 511	0. 06241	7 1, 329, 582	82, 989	90. 00
91.00 Nursing School cost	0	4, 641, 511	0.00000	1, 329, 582	0	91.00
92.00 Allied health cost	0	4, 641, 511	0.00000	1, 329, 582	0	92. 00
93.00 All other Medical Education	o	4, 641, 511	0.00000	1, 329, 582	0	93. 00

Health Financial Systems PARKVIEW WABASH H	IOSPI TAL, INC.		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017		
	Titl∈	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		,			
30. 00 03000 ADULTS & PEDI ATRI CS			1, 553, 538		30. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		,	_		
50. 00 05000 OPERATI NG ROOM		0. 27253			50. 00
51. 00 05100 RECOVERY ROOM		0.00000		0	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00773			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08159		31, 606	54.00
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56.00
60. 00 06000 LABORATORY		0. 17599		64, 667	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
66. 00 06600 PHYSI CAL THERAPY		0. 47511	5 93, 148	44, 256	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 60811	2 57, 192	34, 779	67.00
68. 00 06800 SPEECH PATHOLOGY		1. 69245			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 42747	9 452, 394		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31598	9 49, 338	15, 590	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 29668	1 122	36	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27845	4 739, 905	206, 030	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 24517	5 0	0	90.00
90. 01 09001 SENI OR CARE		1. 06641	4 0	0	90. 01
04 00 00400 EMEDOENOV		0 00054	0 044	0.4	04 00

1. 066414 0. 303543 1. 252584

2, 227, 323

91.00

92.00 0 622, 251 200. 00 201. 00

202. 00

864

91. 00 09100 EMERGENCY

202.00

91.00 OPTION EMERCENCY
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
	Companant (From 01/01/2017 To 12/31/2017	Date/Time Pre	narod:
	Component	CN. 13-2310	10 12/31/2017	5/29/2018 9:5	
	Title	XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			15, 286		30.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		0.07050			
50. 00 05000 OPERATI NG ROOM		0. 27253		0	00.00
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00773		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08159		0	54.00
56. 00 05600 RADI OI SOTOPE		0.00000		0	56. 00
60. 00 06000 LABORATORY	•	0. 17599			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	•	0.00000		0	
66. 00 06600 PHYSI CAL THERAPY	•	0. 47511			
67. 00 06700 OCCUPATI ONAL THERAPY	•	0. 60811			
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		1. 69245		0 6, 776	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 42747	· ·	6, 776	
72. 00 07700 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31598 0. 29668		42	71. 00 72. 00
		0. 27845			
73.00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 27643	4, 345	1, 210	73.00
90. 00 09000 CLINIC		0. 24517	5 0	0	90.00
90. 00 09000 CEI NI C 90. 01 09001 SENI OR CARE		1. 06641		0	90.00
91. 00 09100 SENTOR CARE 91. 00 09100 EMERGENCY		0. 30354			90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 25258			91.00
200 00 Total (sum of Lines 50 through 94 and	1 96 through 98)	1. 25250	28 457	12 178	

92.00 0 12, 178 200. 00 201. 00

202. 00

28, 457

202.00

92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

Health Financial Systems PARKVIEW WABASH HOSP	ITAI INC		In lie	eu of Form CMS-2	2552_10
	Provi der CO	CN: 15-1310	Peri od:	Worksheet D-3	2002 10
THE ATTENT AND EDITION DELIVED SOOT ALL DICTIONS AND ALL	i i ovi dei o		From 01/01/2017		
			To 12/31/2017		
	T: +1	e XIX	Haani tal	5/29/2018 9: 58 PPS	<u>8 am</u>
Cost Center Description	11 (1	Ratio of Cos	Hospi tal	Inpati ent	
Cost Center Description		To Charges	Program	Program Costs	
		10 Charges		(col. 1 x col.	
			Charges	2)	
		1, 00	2, 00	3, 00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			49, 198		30. 00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS			_		
50. 00 05000 OPERATING ROOM		0. 27253	5 2, 775	756	50. 00
51. 00 05100 RECOVERY ROOM		0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00773	8 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08159	4 24, 270	1, 980	54.00
56. 00 05600 RADI 0I SOTOPE		0.00000	0 0	0	56.00
60. 00 06000 LABORATORY		0. 17599	0 22, 602	3, 978	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0 0	0	63.00
66. 00 O6600 PHYSI CAL THERAPY		0. 47511	5 1, 335	634	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 60811		305	67. 00
68. 00 06800 SPEECH PATHOLOGY		1. 69245		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 42747		6, 007	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31598		1	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 29668		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27845	4 29, 310	8, 161	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 24517		0	90. 00
90. 01 09001 SENI OR CARE		1. 06641		0	90. 01

0. 303543 1. 252584

110, 800

91.00

202. 00

0 92.00 26,686 200.00 201. 00

91. 00 09100 EMERGENCY

202.00

91.00 OPTION EMERCENCY
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	Peri od: Worksheet E From 01/01/2017 Part B To 12/31/2017 Date/Time Prepared:

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00				10 12/31/201/	5/29/2018 9:5	pared: 8 am
No. Additional and other services (see Instructions) 0.46, 467, 187 1.10 Additional and other services (see Instructions) 0.2 2.10 2.			Title XVIII	Hospi tal		o am
No. Additional and other services (see Instructions) 0.46, 467, 187 1.10 Additional and other services (see Instructions) 0.2 2.10 2.						
					1. 00	
2.00 Medical and other services relabursed under OPPS (see Instructions) 0 2, 4, 5, 5, 5, 6, 6, 6, 7, 87, 8, 8, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	4 00					1
0 0 0 0 0 0 0 0 0 0			ti onc)			•
0.00			ti ons)			3.00
					_	4.00
Color Colo	4. 01					1
1	5.00	1	ctions)		0.000	l
1.00	6.00				0	6.00
	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
10.00 Organ acquisitions	8.00	1				
11.00 Total cost (sum of lines 1 and 10) (see instructions)			IV, col. 13, line 200		_	9.00
Computation of Lesser of Cost or Charges 0 12.0 14.0 15		9			_	
Reasonable charges	11.00				6, 467, 877	11.00
13.00 Organ acquist tion charges (From Wist. D.4, Pt. III., col. 4, Iiine 69) 0 13.1	12 00				1 0	12.00
1.4 to 1.5 to 1		1	ine 69)			
Customary charges			,		0	l
Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.10 17						ĺ
had such payment been made in accordance with 42 CFR §413.13(e)	15.00					
	16.00			n a chargebasis	0	16. 00
18.00 Total customary charges (see instructions)	17 00		e)		0.000000	17.0
Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19.6						
Instructions			Ly if line 18 exceeds li	ne 11) (see		
Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.532,556 21.0	17.00		Ty IT TITLE TO EXCEEDS IT	116 11) (366		1 7. 00
instructions	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.00
Interns and residents (see instructions) 0 22.0				, ,		
Cost of physicians' services in a teaching hospital (see instructions) 0 23.4	21. 00	,			6, 532, 556	21.00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1			_	
COMPUTATION OF REIMBURSEMENT SETILEMENT SETILEMENT Set			ructions)			ı
Deductibles and coinsurance (for CAH, see instructions)	24.00				0	24.00
Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions) 4,398,782 26, 27, 00	25 00				53 700	25 00
Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see Instructions) 1 rect graduate medical education payments (from Wkst. E-4, line 50) 28.0 28.0 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.01 20.00 20.0		· · · · · · · · · · · · · · · · · · ·	r CAH see instructions)			
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 2	27. 00			and 231 (see		
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 2.080,074 30.00						
Subtotal (sum of lines 27 through 29) 2,080,074 30.0	28. 00		ine 50)		0	28.00
Primary payer payments		1			0	29.00
Subtotal (line 30 minus line 31)		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.0 33.0 34.00 Allowable bad debts (see instructions) 517, 160 34.0 35.00 Adjusted reimbursable bad debts (see instructions) 336, 154 35.0 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 2, 415, 386 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.0 39.00 MSP-LCC reconciliation amount from PS&R 0 38.0 39.00 MSP-LCC reconciliation amount from PS&R 0 38.0 39.00 39.50 MSP-LCC demonstration payment adjustment (see instructions) 39.6 39.50 Poneer ACO demonstration payment adjustment (see instructions) 0 39.0 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.0 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 2, 415, 386 40.0 40.00						
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32.00	,	CES)		2,017,232	32.00
34.00	33. 00	·	020)		0	33.00
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.91 Demonstration payment adjustment amount before sequestration 39.92 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.90 Subtotal (see instructions) 39.90 Subtotal (see instructions) 39.91 Sequestration adjustment (see instructions) 39.91 Subtotal (see instructions) 39.92 Subtotal (see instructions) 39.93 Subtotal (see instructions) 39.94 Subtotal (see instructions) 39.95 Trial or full credits received from manufacturers for replaced devices (see instructions) 39.96 Subtotal (see instructions) 39.97 Subtotal (see instructions) 39.98 Sequestration adjustment (see instructions) 39.99 Subtotal (see instructions) 39.90 Subtotal (see instructions) 39.90 Subtotal (see instructions) 39.91 Subtotal (see instructions) 39.91 Subtotal (see instructions) 39.91 Subtotal (see instructions) 39.92 Subtotal (see instructions) 39.93 Subtotal (see instructions) 39.94 Subtotal (see instructions) 39.95 Subtotal (see instructions) 39.96 Subtotal (see instructions) 39.97 Subtotal (see instructions) 39.98 SECOVERY OF ACCELERATED DEPRECIATION 39.98 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.99 Subtotal (see instructions) 39.90 Subtotal (see instruc		1			517, 160	34.0
37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Demonstration payment adjustment amount after sequestration 40.04 Demonstration payment adjustment amount after sequestration 40.05 Demonstration payment (see instructions) 40.06 Demonstration payment (see instructions) 40.07 Demonstration payment (see instructions) 40.08 Demonstration payment (see instructions) 40.09 Demonstration payment (see instructions) 40.00 Uniter im payments 40.00 Demonstration payment (see instructions) 40.01 Interim payments 40.02 Demonstration payment (see instructions) 40.03 Demonstration payment adjustment amount after sequestration 40.04 Demonstration payment adjustment amount after sequestration 40.05 Demonstration payment adjustment amount after sequestration 40.06 Uniterim payments 40.07 Demonstration payment adjustment amount after sequestration 40.08 Demonstration payment adjustment amount after sequestration 40.09 Demonstration payment adjustment amount after sequestration 40.00 Demonstration adjustment amount after sequestration 40.01 Demonstration adjustment amount after sequestration 40.02 Demonstration adjustment amount (see instructions) 40.03 Demonstration adjustment amount (see instructions) 40.04 Demonstration adjustment amount (see instructions) 40.06 Demonstration adjustment amount (see instructions) 40.07 Demonstration adjustment amount after sequestration 40.08 Demonstration adjustment amount after sequestration 40.09 Demonstration adjustment amount after sequestration 40.00 Demonstration adjustment amount	35.00	Adjusted reimbursable bad debts (see instructions)			336, 154	35.0
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 90.00 Utiler reconciliation adjustment amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 91.00 Time Value of Money (see instructions) 92.00 Time Value of Money (see instructions) 93.60 39.6 39.60 39.6			ructions)			
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 91 Demonstration payment adjustment amount before sequestration 39. 92 APARTIAL OR FULL CREATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 50 40. 01 Demonstration payment adjustment amount after sequestration 60 40. 02 Demonstration payment adjustment amount after sequestration 60 41. 00 Interim payments 61 Tentative settlement (for contractors use only) 42. 00 Bal ance due provider/program (see instructions) 62 Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 1, 10 \$\frac{\f						
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\sqrt{115}}{\sqrt{2}}\$ 15. 2 \text{TO BE COMPLETED BY CONTRACTOR} 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Uttlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Tentation payment adjustment amount (see instructions) 95. 00 Time Value of Money (see instructions) 97. 00 Time Value of Money (see instructions) 98. 00 Time Value of Money (see instructions) 99. 00 Time Value of Money (see instructions)						
Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) To Be COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) O 39.6 39.6 39.6 39.6 39.9 39.6					0	
Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.9 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.6 40.00 Subtotal (see instructions) 2,415,386 40.6 40.01 Sequestration adjustment (see instructions) 48,308 40.6 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 3,093,186 41.0 42.00 Tentative settlement (for contractors use only) 0 42.0 43.00 Balance due provider/program (see instructions) -726,108 43.0 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, , , , , , , , , , , , , , , , , , , ,	5)		0	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 5 Sequestration adjustment (see instructions) 40. 01 Demonstration payment adjustment amount after sequestration 1 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, since Completed By Contractors 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 39. 0 40. 00 39. 0 40. 00 39. 0 44. 00 45. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 93. 00 Time Value of Money (see instructions)			ced devices (see instruc	tions)		1
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Adv. 04.00 Adv.		·	ced devices (see mistrae	11 0113)		
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{TO BE COMPLETED BY CONTRACTOR} 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 0. 00 93. 0	40.00					1
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 40.0 40.0	40. 01					1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.0 -726, 108 43.0 44.0 90.00 91.00 91.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00	40.02					40.0
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 9115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)		Interim payments			3, 093, 186	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Opt.	42.00	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				42.0
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 0 93.00 Time Value of Money (see instructions)	43.00					
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 10 90.00 91.00 91.00 92.00 93.	44. 00		nce with CMS Pub. 15-2,	chapter 1,	0	44.0
90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 93.00 93.00 Outlier reconciliation adjustment amount (see instructions) 0 0 93.00 Outlier reconciliation adjustment amount (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 0.00 92.00 93.00 0.00 0	90 00				0	90 n
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.0		, ,				
93.00 Time Value of Money (see instructions) 0 93.0	92.00	1				1
	93.00				l	1
	94.00				0	94.0

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 Financial
 Systems
 PARKVI

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provider CCN: 15-1310

				10 12/31/201/	5/29/2018 9:58	
		Title	XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		/ 1 1 /		(11)		
		mm/dd/yyyy 1.00	Amount	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	2. 00 1, 920, 35		3, 093, 186	1. 00
2.00	Interim payments payable on individual bills, either			0	3, 093, 186	2.00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider		I	ما		0.04
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		l .	0	0	3. 01 3. 02
3. 02				0		3. 02
3. 03				0		3. 03
3. 05				0	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3. 52			1	0	0	3. 52
3. 53				0	0	3. 53
3. 54	Cultural (1	0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 920, 35	7	3, 093, 186	4. 00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 720, 00		0,0,0,100	11.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		I	ol	T 0	5. 01
5. 02	TERMINE TO THOMBEN			Ö	l o	5. 02
5.03				O	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52	Cultural (0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6.01	SETTLEMENT TO PROVI DER		97, 04	3	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	726, 108	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 017, 40		2, 367, 078	7. 00
				Contractor	NPR Date	
		,	<u> </u>	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
5. 50	Thams of Softi do to	l		1	1	0.00

Health Financial Systems PARKVI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/29/2018 9:58 am Provider CCN: 15-1310 Component CCN: 15-Z310

					5/29/2018 9:5	8 am
				ving Beds - SNF		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		47, 410		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		47, 410		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		Г			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider					- 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	ILMIATIVE TO PROGRAM		0		0	5. 50
5. 51						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
5. 99	5. 50-5. 98)					5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		4, 818		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		52, 228		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.0-
8. 00	Name of Contractor					8. 00

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu					2552-10
From 01/01/2017 Part II To 12/31/2017 Date/Time			Worksheet E-1 Part II Date/Time Pre 5/29/2018 9:5	pared:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wks		2 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 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 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	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31.00
32 00	Balance due provider (Line 8 (or Line 10) minus Line 30 and	line 31) (see instruction	ne)		32 00

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

32.00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1310	Peri od:	Worksheet E-2
			From 01/01/2017	
		Component CCN: 15-Z310	To 12/31/2017	Date/Time Prepared:

		Component Con. 13-2310	10 12/31/2017	5/29/2018 9:5	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient routine services - swing bed-SNF (see instructions)		40, 994	0	
	Inpatient routine services - swing bed-NF (see instructions)				2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		12, 300	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4.00
- 00	instructions)		0.0		- 0
	Program days	notrusti ana)	22	0	
6.00	Interns and residents not in approved teaching program (see in	•		0	6. 00 7. 00
7. 00 8. 00	Utilization review - physician compensation - SNF optional me Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	triod only	E2 204	0	1
	Primary payer payments (see instructions)		53, 294	0	
1	Subtotal (line 8 minus line 9)		53, 294	0	1
1	Deductibles billed to program patients (exclude amounts applic	sable to physician	33, 294	0	1
11.00	professional services)	cable to physician	٩	U	11.00
12. 00	Subtotal (line 10 minus line 11)		53, 294	0	12. 00
1	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	00, 274	0	1
13.00	for physician professional services)	(exertiac corristration	Ĭ	O	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	53, 294	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	1
1	Pioneer ACO demonstration payment adjustment (see instructions	5)			16. 50
	Rural community hospital demonstration project (§410A Demonstr	•	o		16. 5
	adjustment (see instructions)	, []			
16. 99	Demonstration payment adjustment amount before sequestration		o	0	16. 9
17. 00	Allowable bad debts (see instructions)		o	0	17.0
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17.0
18. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)	0	0	18. 0
19. 00	Total (see instructions)		53, 294	0	19.00
	Sequestration adjustment (see instructions)		1, 066	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 0
1	Interim payments		47, 410	0	
1	Tentative settlement (for contractor use only)		0	0	
1	Balance due provider/program (line 19 minus lines 19.01, 20, a	•	4, 818	0	
23. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	0	0	23. 0
	chapter 1, §115.2				-
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			1200 0
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the Zist			200. 0
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from N	Wkst D-1 Pt II line			201. 0
201.00	66 (title XVIII hospital))	wat. b i, it. ii, iiie			201.0
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3. col. 3. lin	e		202. 0
202.00	200 (title XVIII swing-bed SNF))				202.0
203.00	Total (sum of lines 201 and 202)				203. 0
1	Medicare swing-bed SNF discharges (see instructions)				204. 0
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	rati on	
	peri od)				
205.00	Medicare swing-bed SNF target amount				205. 0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 0
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
207.00	Program reimbursement under the §410A Demonstration (see inst	ructions)			207. 0
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208. 0
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 0
	Reserved for future use				210. 0
	Comparision of PPS versus Cost Reimbursement				ļ
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
2.0.00	instructions)				1

Health Financial Systems	PARKVIEW WABASH HOSPI	TAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pı	Provider CCN: 15-1310	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part V Date/Ti me Prepared: 5/29/2018 9:58 am
		Title XVIII	Hospi tal	Cost

				5/29/2018 9:5	8 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PA	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 208, 856	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions	s)		0	2.00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			2, 208, 856	4.00
5.00	Pri mary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 230, 945	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				[
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges			-	
11. 00	Aggregate amount actually collected from patients liable for pay	vment for services on	a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable for p			0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		3		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14. 00	Total customary charges (see instructions)			0	•
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)		, (-	
16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds line	e 14) (see	0	16.00
	instructions)		, ,		
17.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				ĺ
18.00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	•		2, 230, 945	19.00
20.00	Deductibles (exclude professional component)			282, 800	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 948, 145	22. 00
23.00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 948, 145	24.00
25.00	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		169, 886	25. 00
	Adjusted reimbursable bad debts (see instructions)	,		110, 426	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		169, 886	27. 00
	Subtotal (sum of lines 24 and 25, or line 26)	,		2, 058, 571	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	l
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			2, 058, 571	
	Seguestration adjustment (see instructions)			41, 171	•
	Demonstration payment adjustment amount after sequestration			41, 171	•
	Interim payments			1, 920, 357	
	Tentative settlement (for contractor use only)			1, 720, 337	•
	Balance due provider/program (line 30 minus lines 30.01, 30.02,	31 and 32)		97, 043	
34. 00	Protested amounts (nonallowable cost report items) in accordance		chanter 1	97, 043	
5 1. 00	§115. 2	5 til omo rub. 15 2, 1	J	O	5 1. 00
	15				1

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

Provider CCN: 15-1310

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared:

onl y)			'	0 12/31/201/	5/29/2018 9:5	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	896, 683	1	1	0	1.00
2. 00 3. 00	Temporary investments Notes receivable			-	0	2. 00 3. 00
4.00	Accounts receivable	5, 963, 432	1	0	0	4.00
5. 00	Other recei vabl e	-270, 370	1	Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0) c	o	0	6. 00
7.00	Inventory	284, 051	C	0	0	7. 00
8.00	Prepai d expenses	5, 687, 765	1	0	0	
9.00	Other current assets	25, 745, 029	1	0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	-22, 261, 249 16, 045, 341	1	-	0	10.00
11.00	FIXED ASSETS	10, 045, 341	1	ıl U	0	11.00
12. 00	Land	985, 290		0	0	12. 00
13.00	Land improvements	O		O	0	13. 00
14.00	Accumulated depreciation	0) c	0	0	14. 00
15. 00	Bui I di ngs	20, 662, 927	' c	0	0	15. 00
16.00	Accumulated depreciation	-16, 436, 316		-	0	16.00
17. 00	Leasehold improvements	-2, 058	1	-	0	17. 00
18. 00 19. 00	Accumulated depreciation Fixed equipment	117, 827) C		0	18. 00 19. 00
20. 00	Accumulated depreciation	-96, 051	1	-	0	20.00
21. 00	Automobiles and trucks	23, 432	1	o	0	21. 00
22.00	Accumulated depreciation	-23, 431	C	0	0	22. 00
23. 00	Major movable equipment	3, 264, 478	3 C	0	0	23. 00
24. 00	Accumulated depreciation	-2, 164, 233	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0		-	0	25. 00
26. 00	Accumulated depreciation			-	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation			0	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e			Ö	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	6, 331, 865		o	0	30.00
	OTHER ASSETS					
31. 00	Investments	206, 748			0	31.00
32. 00	Deposits on Leases	0		-	0	32.00
33. 00 34. 00	Due from owners/officers Other assets				0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	206, 748	1	-	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	22, 583, 954	1	1	0	36.00
	CURRENT LI ABI LI TI ES			-,		
37. 00	Accounts payable	3, 451, 717	r C	0	0	37. 00
38. 00	Salaries, wages, and fees payable	461, 059	1	٦	0	38. 00
39. 00	Payroll taxes payable	0		0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income			0	0	40. 00 41. 00
41.00	Accel erated payments	0		, o	0	42.00
43. 00	Due to other funds		ól c	o	0	1
44.00	Other current liabilities	2, 042, 797	d c	o	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	5, 955, 573		0	0	45. 00
	LONG TERM LIABILITIES			T		
46. 00	Mortgage payable	0		-	0	
47. 00 48. 00	Notes payable Unsecured Loans				0	
49. 00	Other long term liabilities	24, 531, 826	1	-	0	49.00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	24, 531, 826	l .		0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30, 487, 399		O	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	-7, 903, 445				52. 00
53. 00	Specific purpose fund		C			53. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	-7, 903, 445	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	22, 583, 954	·l C	l 이	0	60.00
	[59]	I	I	1		I

In Lieu of Form CMS-2552-10 Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1310 Peri od: Worksheet G-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 9:58 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -743, 891 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -7, 159, 553 2.00 3.00 Total (sum of line 1 and line 2) -7, 903, 444 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) -7, 903, 444 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -7, 903, 444 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00

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19.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

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

			10	12/31/201/	Date/IIme Prep 5/29/2018 9:58	
	Cost Center Description	Inpatient		Outpati ent	Total	J dill
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	3, 171,	514		3, 171, 514	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF	58,	580		58, 580	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 230,	094		3, 230, 094	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lin	es	0		0	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 230,			3, 230, 094	
18. 00	Ancillary services	6, 105,		0	6, 105, 759	18. 00
19. 00	Outpati ent servi ces		0	90, 863, 146	90, 863, 146	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			165, 297	165, 297	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		_	200 270	200 270	25. 00
26.00	HOSPI CE		0	200, 368	200, 368	
27. 00	OTHER (SPECIFY)	Mko+ 0.33E	OE 3	01 220 011	100 5/4 //4	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 9,335,	853	91, 228, 811	100, 564, 664	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			41, 634, 088		29. 00
30. 00	BAD DEBT	4, 068,	850	41, 034, 000		30.00
31. 00	DAD DEDT	4,000,	0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		O	4, 068, 850		36. 00
37. 00	DEDUCT (SPECIFY)		0	4, 000, 000		37. 00
38. 00	DEDUCT (GLEGITT)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			n			41. 00
42. 00	Total deductions (sum of lines 37-41)		Ĭ	n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		45, 702, 938		43. 00
	to Wkst. G-3, line 4)			, , , , , , ,		
	1	1	ļ	'		

	Financial Systems PARKVIEW WABASH F			u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1310	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			10 12/31/201/	5/29/2018 9:58	8 am
		·			
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, Ii	ne 28)		100, 564, 664	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	unts		63, 576, 853	2. 00
3.00	Net patient revenues (line 1 minus line 2)			36, 987, 811	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		45, 702, 938	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-8, 715, 127	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			6, 789	6. 00
7.00	Income from investments			679. 087	7. 00

Revenues from telephone and other miscellaneous communication services

Revenue from sale of medical and surgical supplies to other than patients

Revenue from television and radio service

Revenue from meals sold to employees and guests

Revenue from sale of drugs to other than patients

Revenue from sale of medical records and abstracts

Tuition (fees, sale of textbooks, uniforms, etc.)

Revenue from gifts, flowers, coffee shops, and canteen

Revenue from Laundry and Linen service

Revenue from rental of living quarters

Total other income (sum of lines 6-24)

28.00 Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

Rebates and refunds of expenses

Rental of vending machines

Governmental appropriations

Total (line 5 plus line 25)

Rental of hospital space

OTHER OPERATING REVENUE

OTHER EXPENSES (SPECIFY)

24.00 GAIN ON DISPOSAL OF ASSETS

Purchase di scounts

Parking lot receipts

8.00

9.00

10.00

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-7, 159, 553 29. 00

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167, 385

159, 918

103, 099

1, 555, 574

-7, 159, 553

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26.00

		7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. &	0	0	0	0	1. 00
	Fixtures					
2.00	Capital Related - Movable	0	0	O	0	2. 00
	Equi pment					
3.00	Plant Operation & Maintenance	0	0	0	0	3. 00
4.00	Transportation	0	0	0	0	4. 00
5.00	Administrative and General	0	95, 048	0	95, 048	5. 00
	HHA REIMBURSABLE SERVICES					1
6.00	Skilled Nursing Care	0	39, 698	0	39, 698	6. 00
7.00	Physical Therapy	0	40, 312	0	40, 312	7. 00
8.00	Occupational Therapy	0	7, 306	O	7, 306	8. 00
9.00	Speech Pathology	0	1, 780	O	1, 780	9. 00
10.00	Medical Social Services	0	0	O	0	10.00
11. 00	Home Health Aide	0	10, 008	O	10, 008	11. 00
12.00	Supplies (see instructions)	0	17, 771	O	17, 771	12. 00
13.00	Drugs	0	0	O	0	13. 00
14.00	DME	0	O	O	0	14. 00
	HHA NONREIMBURSABLE SERVICES					1
15.00	Home Dialysis Aide Services	0	0	0	0	15. 00
16.00	Respiratory Therapy	0	0	O	0	16. 00
17.00	Private Duty Nursing	0	0	o	0	17. 00
18.00	Clinic	0	0	o	0	18. 00
19.00	Health Promotion Activities	0	O	O	0	19. 00
20.00	Day Care Program	0	O	O	0	20.00
21.00	Home Delivered Meals Program	0	O	O	0	21. 00
22. 00	Homemaker Service	0	o	O	0	22. 00
23.00	All Others (specify)	0	o	O	0	23. 00
23. 50	Tel emedi ci ne	0	o	O	0	23. 50
24. 00	Total (sum of lines 1-23)	0	211, 923	o	211, 923	24. 00

Trial Balance

(col. 6 +

col . 7)

for Allocation

(col. 8 + col. 9)

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211, 923

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Clinic

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16.00

17.00

18.00

19.00

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21.00

22 00

23.00

23.50

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		ARKVIEW WABASH	Provider Co	CN: 15-1310	Peri od:	worksheet H-1	
				HHA CCN:	15-7061	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 9:58	:pared: 8 am
						Home Health	PPS	
		Canital Rel	ated Costs			Agency I		
		Capi tai Kei	atca 60313					
		Bl dgs &	Movabl e	Pl ant		onReconciliation		1
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures		_			_		
2.00	Capital Related - Movable		0			0		2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see		0	0		0		4.00
00	instructions)							
5.00	Administrative and General	0	0	0		0 -95, 048	116, 875	5. 00
	HHA REIMBURSABLE SERVICES							4
6.00	Skilled Nursing Care	0	0	0		0 0		
7.00	Physical Therapy	0	0	0		0 0	.0,0.2	•
8. 00 9. 00	Occupational Therapy Speech Pathology	0	0	0		0 0	,,,,,,	
10.00	Medical Social Services		0	0		0 0		1
11. 00	Home Heal th Aide	0	0	0		0 0	10, 008	
12. 00	Supplies (see instructions)	Ö	Ö	Ö		0 0		1
13. 00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0		0 0	0	14.00
45 00	HHA NONREI MBURSABLE SERVI CES	1			T			
15.00	Home Dialysis Aide Services	0	0	0		0 0	-	1
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0	0	16. 00 17. 00
18. 00	Clinic		0	0		0 0	0	18.00
19. 00	Health Promotion Activities	0	0	Ö		0 0	اً م	19.00
20. 00	Day Care Program	0	0	0		0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0		0 0	O	21. 00
22. 00	Homemaker Service	0	0	0		0	0	22.00
23. 00	All Others (specify)	0	0	0		0	0	23.00
23. 50	Telemedicine		0	0		0 05 040	114 075	23. 50
24. 00 25. 00	Total (sum of lines 1-23) Cost To Be Allocated (per	0	0	0		0 -95, 048	116, 875 95, 048	
∠3.00	Worksheet H-1, Part I)				1	o e	90, 048	25.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	20	0. 813245	26 00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-1310 Peri od: Worksheet H-2 From 01/01/2017 Part I 15-7061 То 12/31/2017 Date/Time Prepared: HHA CCN: 5/29/2018 9:58 am Home Health **PPS** Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ADMI NI STRATI VE HHA Trial BLDG & FIXT Subtotal Cost Center Description Bal ance (1) **BENEFITS** & GENERAL DEPARTMENT 0 1.00 2.00 4. 00 5. 00 4A 1.00 Administrative and General 2, 227 3, 754 44, 524 50, 505 24, 240 1.00 71, 982 Skilled Nursing Care 71, 982 34, 547 2 00 2 00 C C 3.00 Physical Therapy 73, 095 0 0 0 73, 095 35, 082 3.00 4.00 Occupational Therapy 13, 248 0 0 0 0 0 13, 248 6, 358 4.00 Speech Pathology 3, 228 0 3, 228 5 00 Ω 1, 549 5 00 0 6.00 Medical Social Services C 6.00 7.00 Home Heal th Aide 18, 147 18, 147 8, 710 7.00 8.00 Supplies (see instructions) 32, 223 0000000000 0 0 32, 223 15, 465 8.00 0 9.00 Ω 9 00 Drugs 0 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 0 Respiratory Therapy 0 12.00 12.00 0 0 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 14.00 Health Promotion Activities 0 15.00 15.00 0 Day Care Program 0 0 0 16, 00 16.00 0 17 00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 0 18.00 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 19.50 0 0 0 211, 923 3, 754 20.00 Total (sum of lines 1-19) (2) 2.227 44.524 262, 428 125, 951 20.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG **PLANT** LINEN SERVICE ADMI NI STRATI ON 7.00 8.00 9.00 10.00 11.00 13.00 1.00 Administrative and General 18, 992 0 10, 837 1 00 0 0 2.00 Skilled Nursing Care 0 2.00 3.00 Physical Therapy 0 0 0 3.00 0 0 4.00 Occupational Therapy 0 4.00 0 0 Speech Pathology 5 00 Ω 5 00 6.00 Medical Social Services 0 0 6.00 7.00 Home Health Aide 7.00 8 00 0 0 O 8.00 Supplies (see instructions)

00000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 9.00 Drugs 0 0 9.00 10.00 DME 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 12 00 12 00 Respiratory Therapy Ω 13.00 Private Duty Nursing 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 15.00 0 15.00 0 0 Day Care Program Ω ol 16.00 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 18.00 18.00 0 All Others (specify) 0 0 19.00 0 0 19.00 19.50 Tel emedi ci ne 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 18, 992 10,837 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	Financial Systems		KKALEM MARAZH I			In Lie	eu of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS 1	TO HHA COST CENT	TERS	Provider C	CN: 15-1310 15-7061	Peri od: From 01/01/2017 To 12/31/2017		
-						Home Health	PPS	o alli
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Agency I Intern & Residents Cost & Post Stepdown	Subtotal	
		14. 00	15. 00	16. 00	24.00	Adjustments 25.00	26.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	1, 157 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	105, 7 106, 5 108, 1 19, 6 4, 7 26, 8 47, 6	311 00 299 00 777 00 66 00 777 00 557 00 888 00	105, 731 106, 529 108, 177 19, 606 4, 777	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
	6 decimal places. Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
1.00	Ta	27. 00	28. 00					1.00
12. 00 13. 00 14. 00 15. 00 16. 00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	35, 913 36, 469 6, 609 1, 610 9, 054 16, 076 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	142, 442 144, 646 26, 215 6, 387 0 35, 911 63, 764 0 0 0 0 0 0 0 0 0 0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00

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

BASIS HHA CCN: 15-7061 Home Health PPS

						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			Agency 1		
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	PLANT	
				DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
				(GROSS				
		1.00	2. 00	SALARI ES)	5A	5. 00	7. 00	
1.00	Administrative and General	906	906	4. 00 169, 783			906	1. 00
2. 00	Skilled Nursing Care	0	0				0	2. 00
3.00	Physical Therapy	l ő	0	1	1		0	3. 00
4. 00	Occupational Therapy	0	0	1		l	Ö	4. 00
5.00	Speech Pathology	0	0	C		l	0	5. 00
6.00	Medical Social Services	0	0	0) c	0	0	6. 00
7.00	Home Health Aide	0	0	0) c	18, 147	0	7. 00
8.00	Supplies (see instructions)	0	0	0) c	32, 223	0	8. 00
9. 00	Drugs	0	0		1	0	0	9. 00
10. 00	DME	0	0			0	0	10. 00
11.00	Home Dialysis Aide Services	0	0		1	0	0	11. 00
12. 00 13. 00	Respiratory Therapy	0	0			-	0	12.00
14. 00	Private Duty Nursing		0	1	1		0	13. 00 14. 00
15. 00	Health Promotion Activities		0		1	0	0	15. 00
16. 00	Day Care Program	0	0		ól	Ö	Ö	16. 00
17. 00	Home Delivered Meals Program	l ő	0			o	Ö	17. 00
18.00		0	0	O) c	o	0	18. 00
19. 00	All Others (specify)	0	0	0) c	0	0	19.00
19. 50	II	0	0	0) c	0	0	19. 50
20. 00	Total (sum of lines 1-19)	906	906		1	262, 428	906	
21. 00	Total cost to be allocated	2, 227	3, 754			125, 951	18, 992	
22. 00	Unit cost multiplier Cost Center Description	2. 458057 LAUNDRY &	4. 143488	0. 262241 DI ETARY	CAFETERI A	0. 479945 NURSI NG	20. 962472 CENTRAL	22. 00
	cost center bescription	LINEN SERVICE	HOUSEKEEPING	(MEALS SERVED)		ADMI NI STRATI ON	SERVICES &	
		(POUNDS OF	(SQUARE TELT)	(WENES SERVED)	(11001(3)	ADMINI STRATI ON	SUPPLY	
		LAUNDR)				(DI RECT NRS	(COSTED	
						ING HR)	REQUIS.)	
	1	8. 00	9. 00	10.00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	906		1	-	9, 048	1. 00
2. 00 3. 00	Skilled Nursing Care	0	0			0	0	2. 00 3. 00
4.00	Physical Therapy Occupational Therapy		0	1	1	0	0	
5.00	Speech Pathology		0	1	1		0	5. 00
6. 00	Medical Social Services	0	0	1	1	0	0	6. 00
7. 00	Home Heal th Aide	0	0	l o		o	0	7. 00
8.00	Supplies (see instructions)	0	0	O) c	0	0	8. 00
9.00	Drugs	0	0	0) c	0	0	9. 00
10.00	DME	0	0	1) c	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	-) C	0	0	11. 00
12.00	Respiratory Therapy	0	0	1		0	0	12.00
13.00	Private Duty Nursing	0	0	0		0	0	
15. 00	Clinic Health Promotion Activities		0				0	
16. 00	Day Care Program		0				0	16. 00
17. 00	Home Delivered Meals Program	0	0	1		ol ol	0	17. 00
18. 00	Homemaker Service	0	0	O		o	0	
19. 00	All Others (specify)	0	0	0) c	o	0	
19. 50	Tel emedi ci ne	0	0) c	o	0	
20. 00		0	906) C	0	9, 048	
21. 00	Total cost to be allocated	0	10, 837		0	0	1, 157	
22. 00	Unit cost multiplier	0. 000000	11. 961369	0.000000	0.000000	0. 000000	0. 127874	22. 00

Health Financial Systems	P/	ARKVIEW WABASH HO	'IEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
ALLOCATION OF GENERAL SERVICE COSTS T	LLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTIC				Peri od:	Worksheet H-2			
BASIS					From 01/01/2017	Part II			
B.O. C			HHA CCN:	15-7061	To 12/31/2017	Date/Time Prep 5/29/2018 9:58	pared: 8 am		
					Home Health	PPS			
					Agency I				
Cost Center Description	PHARMACY	MEDI CAL							
,	(COSTED	RECORDS &							
	REQUIS.)	LI BRARY							
	ŕ	(GROSS REV)							
	15. 00	16.00							
1.00 Administrative and General	0	0					1. 00		

				Agency I	
	Cost Center Description	PHARMACY	MEDI CAL		
		(COSTED	RECORDS &		
		REQUIS.)	LI BRARY		
			(GROSS REV)		
		15. 00	16. 00		
1.00	Administrative and General	0	0		1.00
2.00	Skilled Nursing Care	0	0		2. 00
3.00	Physi cal Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4. 00
5.00	Speech Pathology	0	0		5. 00
6.00	Medical Social Services	0	0		6. 00
7.00	Home Health Aide	0	0		7. 00
8.00	Supplies (see instructions)	0	0		8. 00
9.00	Drugs	0	o		9. 00
10.00	DME	0	O		10.00
11. 00	Home Dialysis Aide Services	0	0		11. 00
12.00	Respiratory Therapy	0	0		12. 00
13.00	Private Duty Nursing	0	0		13. 00
14.00	Clinic	0	0		14. 00
15.00	Health Promotion Activities	0	0		15. 00
16.00	Day Care Program	0	0		16. 00
17. 00	Home Delivered Meals Program	0	O		17. 00
18.00	Homemaker Service	0	O		18. 00
19.00	All Others (specify)	0	O		19. 00
19. 50	Tel emedi ci ne	0	0		19. 50
20.00	Total (sum of lines 1-19)	0	o		20. 00
21.00	Total cost to be allocated	0	o		21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000		22. 00

	rinancial Systems FIONMENT OF PATLENT SERVICE COST		ARKVIEW WABASH		CN: 15-1310	Peri od:	u of Form CMS-2 Worksheet H-3	
				HHA CCN:	15-7061	From 01/01/2017 To 12/31/2017	Part I Date/Time Prep 5/29/2018 9:5	pared: 8 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols.	1	Per Visit (col. 3 ÷ col.	
		COI . 20, TITIE	п-2, Pait I)	Part II)	+ 2)		4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	2. 00	142, 442		142, 44	12 186	765. 82	1.00
2.00	Physi cal Therapy	3.00			1		826. 55	
3.00	Occupational Therapy	4. 00		0	,-		546. 15	1
4.00	Speech Pathology	5. 00		0	6, 38		0. 00	
5.00	Medical Social Services	6.00			25.0	0 0	0.00	
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	7.00	35, 911 355, 601	0	35, 9° 355, 60		1, 795. 55	6. 00 7. 00
7.00	Total (sam of Times 1 o)		000,001	0	Program Visi			7.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					Deducti bl es Coi nsurance			
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	l .	21		8. 00
9.00	Physical Therapy		99915	0	l .	75		9.00
10. 00 11. 00	Occupational Therapy Speech Pathology	•	99915 99915	0	i	18 O		10.00
12. 00	1.		99915	0		0		12.00
13. 00	Home Heal th Ai de		99915	Ö		O		13. 00
14.00	Total (sum of lines 8-13)			0		14		14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11116	п-2, Pait I)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							1
15.00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00				0 0	0. 000000 0. 000000	1
10.00	Cost of brugs	7.00	Program Visits		Cost of	0 0	0.000000	10.00
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &		
			Coinsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIN	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							1
1. 00	Cost Per Visit Computation Skilled Nursing Care	1 0	121			0 92,664		1.00
2.00	Physical Therapy					0 144, 646		2.00
3. 00	Occupational Therapy	0	48			0 26, 215		3. 00
4.00	Speech Pathology	0	0			0 0		4. 00
5.00	Medical Social Services	0	0			0 0		5. 00
6.00	Home Heal th Ai de	0	0			0 0		6.00
7. 00	Total (sum of lines 1-6) Cost Center Description	U	344			0 263, 525		7. 00
	oost deficer bescription	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8. 00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy Speech Pathology							10.00
11 00	Lapacon Latilli dyy	I .	ı		I			
11. 00 12. 00	Medical Social Services							l 12 nn
11. 00 12. 00 13. 00	1							12. 00 13. 00

Heal th	Financial Systems	P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		Provider CC	CN: 15-1310 15-7061	Peri od: From 01/01/2017 To 12/31/2017		pared:
				Title	XVIII	Home Health	PPS	
						Agency I		
		Prog			Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance		
		6, 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Comput			5.55				
15.00	Cost of Medical Supplies	C	0	0		0 0	0	15. 00
16.00	Cost of Drugs		0	0		0	0	16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							
4 00	Cost Per Visit Computation	00.774						4 00
1.00	Skilled Nursing Care	92, 664						1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	144, 646 26, 215						2. 00 3. 00
4. 00	Speech Pathology	20, 215						4. 00
5. 00	Medical Social Services							5. 00
6. 00	Home Heal th Aide							6.00
7. 00	Total (sum of lines 1-6)	263, 525						7. 00
7.00	Cost Center Description	203, 320						7.00
	oost denter beserretron	12. 00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8. 00
9.00	Physical Therapy							9. 00
	Occupational Therapy							10.00
	Speech Pathology							11.00
	Medical Social Services							12.00
13.00	Home Health Aide							13. 00
14.00	Total (sum of lines 8-13)							14. 00

Heal th	Financial Systems	HOSPITAL, INC.		In Lie	2552-10			
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der Co		Peri od:	Worksheet H-3	
					15-7061	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Home Health	PPS			
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 475115	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 608112	0)	0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	1. 692450	0)	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 315989	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 278454	0		0 col. 2, line 1	6. 00	5. 00

		SH HOSPITAL, INC.		In Lieu of Form CMS-2552-1		
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-1310	Peri od: From 01/01/2017	Worksheet H-4 Part I-II	
		HHA CCN:	15-7061	To 12/31/2017	Date/Time Pre	
		Ti +l e	: XVIII	Home Health	5/29/2018 9:5	8 am
		11 11 0		Agency I		
			D A	Par		
			Part A	Not Subject to Deductibles &	Subject to Deductibles &	
				Coi nsurance	Coi nsurance	
	DART I COMPUTATION OF THE LEGGED OF DESCRIPTION OF	OUGTONA DV. OUA DOE	1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR Reasonable Cost of Part A & Part B Services	CUSTOMARY CHARGE	<u>S</u>			
1.00	Reasonable cost of services (see instructions)			0 0	0	1.00
2. 00	Total charges			0 0	0	2.0
3. 00	Customary Charges Amount actually collected from patients liable for payments	at for sorvices	Γ	0 0	0	3.0
5. 00	on a charge basis (from your records)	it for services		0	U	3.0
1.00	Amount that would have been realized from patients liable			0 0	0	4.00
	for services on a charge basis had such payment been made	e in accordance				
5. 00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5.00
5. 00	Total customary charges (see instructions)			0 0	0	6. 00
7. 00	Excess of total customary charges over total reasonable of	cost (complete		0 0	0	7.00
3. 00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (comple:	te only if line		0	0	8.00
, 00	1 exceeds line 6)				· ·	0.0.
9. 00	Pri mary payer amounts			0 0	0	9. 00
				Part A Servi ces	Part B Servi ces	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					1 40 00
10. 00 11. 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	68, 340	10.00
	Total PPS Reimbursement - Full Episodes with Outliers			0	4, 915	
13.00	Total PPS Reimbursement - LUPA Episodes			0	2, 436	1
14. 00 15. 00	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outl	lions		0	1, 313 136	1
16. 00	Total PPS Outlier Reimbursement - PEP Episodes With Outl	reis		0	0	
17. 00	Total Other Payments			0	0	1
18.00	DME Payments			0	0	18.0
9. 00	Oxygen Payments Prosthetic and Orthotic Payments			0	0	19. 0 20. 0
	Part B deductibles billed to Medicare patients (exclude o	coi nsurance)			0	21.0
22. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	77, 140	1
23. 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	77 140	
24. 00 25. 00	Coinsurance billed to program patients (from your records	5)		U	77, 140 0	25.0
26. 00	Net cost (line 24 minus line 25)	2)		0	77, 140	ı
	Reimbursable bad debts (from your records)					27. 0
	Reimbursable bad debts for dual eligible beneficiaries (Total costs - current cost reporting period (line 26 plus			0	77, 140	28. 0 29. 0
		S ITTIE 27)		0	77, 140	1
30. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	0	30. 50
30. 99	Demonstration payment adjustment amount before sequestra	ti on		0	0	
31. 00 31. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			0	77, 140 1, 540	
	Demonstration payment adjustment amount after sequestrati	on		0	1, 540	1
32. 00	Interim payments (see instructions)			0	75, 600	32.00
	Tentative settlement (for contractor use only)	22 4 22)		0	0	
34. 00 35. 00	Balance due provider/program (line 31 minus lines 31.01, Protested amounts (nonallowable cost report items) in acc		Pub 15_2	0	0	l
	THE VICE TWO DISCUSSIONS AS A CONTRACT OF THE SECOND CONTRACT OF THE	SOLUGINGE WELLE CIVIS	TUD. IDEZ.			

Health Financial Systems PARKVIEW WABASH BENALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-1310 Peri od: From 01/01/2017 To 12/31/2017 Worksheet H-5 Date/Time Prepared: 5/29/2018 9:58 am HHA CCN: 15-7061

				Home Health Agency I	PPS	
		Inpatien	t Part A		t B	
		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			0	75, 600 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				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0 0	3. 04 3. 05
3.00	Provider to Program			U <u> </u>	0	3. 03
3.50	Trovider to Trogram			ol	0	3. 50
3. 51				O	0	3. 51
3.52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1	0	75, 600	4. 00
	(transfer to Wkst. H-4, Part II, column as appropriate, line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	r regram to 11 ovr do.			0	0	5. 01
5.02				o	0	5. 02
5. 03				0	0	5. 03
	Provider to Program				1	
5.50				0	0	5. 50
5. 51 5. 52				0	0 0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 52 5. 99
5. 77	5. 50-5. 98)					J. 77
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			Ö	Ö	6. 02
7.00	Total Medicare program liability (see instructions)			0	75, 600	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 15-1310 Peri od: Worksheet 0 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 9:58 am Hospi ce CCN: 15-1545

						3/29/2010 9.3	O GIII
		0.11.451.50	071155	loupzoza, ()	Hospi ce I	OURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00	2.00	1 plus col. 2)	CATI ONS	F 00	
	OFNEDAL CEDIU OF COCT CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				al		
1.00	CAP REL COSTS-BLDG & FIXT*		Ü	0	0	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	8, 421	88, 627	97, 048	0	97, 048	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPI NG*	O	0	0	0	0	7. 00
8.00	DI ETARY*	l ol	0	o	o	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*		1, 427	1, 427	0	1, 427	10.00
11. 00	MEDI CAL RECORDS*		1, 12,	1, 12,	0	0	11. 00
12. 00	STAFF TRANSPORTATION*		6, 824	6, 824	0	6, 824	12.00
			0, 024	0, 024	0		•
13.00	VOLUNTEER SERVICE COORDINATION*	0	11 5/0	11 5/0	U	11 5(2	13.00
14.00	PHARMACY*	0	11, 562	11, 562	0	11, 562	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE*	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES**	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER**	3, 200	0	3, 200	0	3, 200	27. 00
28.00	REGI STERED NURSE**	34, 811	0	34, 811	o	34, 811	28. 00
29.00	LPN/LVN**	ol	0	o	o	0	29. 00
30. 00	PHYSI CAL THERAPY**	36	0	36	0	36	30.00
31. 00	OCCUPATI ONAL THERAPY**	0	0	0	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**		0	0	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	9, 994	0	9, 994	0	9, 994	33. 00
34. 00	SPIRITUAL COUNSELING**	7, 774	0	7, 774	0	0, 774	34.00
35. 00	DI ETARY COUNSELING**		0		0	0	35. 00
			0	0	0	0	•
36.00	COUNSELING - OTHER**	0.047	U	0.047	U	-	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	9, 847	U	9, 847	0	9, 847	37. 00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATIENT TRANSPORTATION**	0	0	0	0	0	39. 00
40. 00	I MAGI NG SERVI CES**	0	0	0	0	0	40. 00
41.00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42. 00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	o	0	0	O	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	o	0	0	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	o	0	0	0	0	46. 00
	NONREI MBURSABLE COST CENTERS	-1		- 1	-		
60. 00	BEREAVEMENT PROGRAM *		0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM *		0		0	0	61.00
62. 00	FUNDRAI SI NG*		0		0	0	62.00
63. 00			0		0	0	1
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	U	l o	U	-	64.00
	OTHER PHYSI CI AN SERVI CES*	0	U	0	0	0	65.00
66. 00	RESI DENTI AL CARE*	0	Ü	0	0	0	66. 00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	미	이	0	68. 00
	THRI FT STORE*	0	O	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
100.00	TOTAL	66, 309	108, 440	174, 749	0	174, 749	100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, co	lumn 1 line as	annronri ate				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 9:58 am Hospi ce CCN: 15-1545 Hospi ce I

				Hospi ce I	
		ADJUSTMENTS :	TOTAL (col. 5		
			± col. 6)		
	T	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		_		
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	97, 048		4. 00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0		5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6. 00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	1, 427		10.00
11.00	MEDI CAL RECORDS*	0	0		11. 00
12.00	STAFF TRANSPORTATION*	0	6, 824		12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13. 00
14.00	PHARMACY*	0	11, 562		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
25 00	DI RECT PATIENT CARE SERVICE COST CENTERS INPATIENT CARE-CONTRACTED**	O	0		25. 00
25. 00 26. 00	PHYSICIAN SERVICES**		0		26. 00
27. 00			- 1		26.00
28. 00	NURSE PRACTITIONER** REGISTERED NURSE**	0	3, 200		28.00
29. 00	LPN/LVN**		34, 811 0		29.00
30.00	PHYSI CAL THERAPY**		36		30.00
31. 00	OCCUPATIONAL THERAPY**		0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**		0		32.00
33. 00	MEDICAL SOCIAL SERVICES**		9, 994		33.00
34. 00	SPIRITUAL COUNSELING**		0, 774		34.00
35. 00	DI ETARY COUNSELI NG**		0		35. 00
36. 00	COUNSELING - OTHER**		0		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	9, 847		37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	l ol	0		38.00
39. 00	PATIENT TRANSPORTATION**	o	0	l .	39.00
40. 00	IMAGING SERVICES**	o	0		40.00
41. 00	LABS & DI AGNOSTI CS**	0	0		41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42. 50	DRUGS CHARGED TO PATI ENTS**	0	0		42. 50
43. 00	OUTPATIENT SERVICES**	0	0		43.00
44. 00	PALLIATIVE RADIATION THERAPY**	o	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	o	0		45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	O	0		46. 00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64. 00
65. 00	OTHER PHYSICIAN SERVICES*	0	0		65. 00
66. 00	RESI DENTI AL CARE*	0	0		66. 00
67. 00	ADVERTI SI NG*	0	0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68. 00
69. 00	THRI FT STORE*	0	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00		0	174, 749		100. 00
* T	-f +l				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

 Heal th Financial Systems
 PARKVIEW WABASH HOSPITAL, INC.

 ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS
 Provider C
 Provider CCN: 15-1310 Peri od: Worksheet 0-1 From 01/01/2017 To 12/31/2017 HOME CARE Date/Time Prepared: 5/29/2018 9:58 am Hospi ce CCN: 15-1545

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	0	0	0	0	0	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	o	0	34.00
35.00	DI ETARY COUNSELI NG	O	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	O	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	O	0	0	o	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	o	0	0	o	0	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42. 00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	o	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	0	o	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	o	0	46. 00
	TOTAL *	o	0	0	o	0	100. 00
* Trop	efor the emount in column 7 to Wket O.E. colu	ump 1 Line FO		•			

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

	Transfer the amount in column 7 to wast. 0-3, column 1, fine 30.						
		ADJUSTMENTS	TOTAL (col. 5				
			± col. 6)				
		6. 00	7. 00				
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED			25.0			
26.00	PHYSI CI AN SERVI CES	0	0	26.0			
27. 00	NURSE PRACTITIONER	0	0	27. 0			
28. 00	REGI STERED NURSE	0	0	28. 0			
29. 00	LPN/LVN	0	0	29. 0			
30.00	PHYSI CAL THERAPY	0	0	30.0			
31.00	OCCUPATI ONAL THERAPY	0	0	31. 0			
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.0			
33.00	MEDICAL SOCIAL SERVICES	0	0	33.0			
34.00	SPIRITUAL COUNSELING	0	0	34.0			
35.00	DI ETARY COUNSELI NG	0	0	35.0			
36.00	COUNSELING - OTHER	0	0	36.0			
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.0			
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.0			
39.00	PATIENT TRANSPORTATION	0	0	39.0			
40.00	I MAGING SERVICES	0	0	40.0			
41.00	LABS & DIAGNOSTICS	0	0	41. 0			
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.0			
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.5			
43.00	OUTPATIENT SERVICES	0	0	43.0			
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 0			
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 0			
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.0			
	TOTAL *	0	0	100.0			

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME Provider C Provider CCN: 15-1310 Peri od: Worksheet 0-2 From 01/01/2017 To 12/31/2017 CARE Date/Time Prepared: 5/29/2018 9:58 am Hospi ce CCN: 15-1545

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	3, 145	0	3, 145	0	3, 145	27. 00
28. 00	REGI STERED NURSE	34, 207	0	34, 207	0	34, 207	28. 00
29.00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	36	0	36	0	36	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	o	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	o	0	0	o	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	9, 822	0	9, 822	o	9, 822	33. 00
34.00	SPIRITUAL COUNSELING	o	0	0	o	0	34. 00
35.00	DI ETARY COUNSELI NG	o	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	0	0	o	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9, 677	0	9, 677	o	9, 677	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	O	0	o	o	0	38. 00
39.00	PATI ENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	o	0	O	o	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	O	o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	О	o	0	46. 00
	TOTAL *	56, 887	0	56, 887	o	56, 887	100. 00
* T	-f th	1 1: 51			•		

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Transfer the amount in corumn 7 to wast. 0-5, co	· ·		
	ADJUSTMENTS	TOTAL (col. 5	
		± col . 6)	
DURENT BATTERIT GARE GERMAN GOOT GENTERS	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			05.00
25. 00 INPATIENT CARE-CONTRACTED			25. 00
26. 00 PHYSI CI AN SERVI CES		0	26. 00
27. 00 NURSE PRACTITIONER		3, 145	27. 00
28. 00 REGI STERED NURSE	C	34, 207	28. 00
29. 00 LPN/LVN	C	0	29. 00
30. 00 PHYSI CAL THERAPY	C	36	30.00
31. 00 OCCUPATI ONAL THERAPY	C	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32. 00
33. 00 MEDICAL SOCIAL SERVICES	C	9, 822	33.00
34.00 SPIRITUAL COUNSELING	C	0	34.00
35. 00 DI ETARY COUNSELING	C	0	35. 00
36. 00 COUNSELING - OTHER	C	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	9, 677	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	0	38.00
39.00 PATIENT TRANSPORTATION	C	0	39.00
40.00 I MAGI NG SERVI CES	C	0	40.00
41.00 LABS & DIAGNOSTICS	C	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	C	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	C	0	42. 50
43.00 OUTPATIENT SERVICES	C	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	C	o	44.00
45.00 PALLIATIVE CHEMOTHERAPY	C	o	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	o	46.00
100. 00 TOTAL *	C	56, 887	100.00
*			

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Health Financial Systems PARKVIEW WABA
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT Provider CCN: 15-1310 RESPITE CARE

Peri od: Worksheet 0-3 Provider CCN: 15-1310 | Period: | From 01/01/2017 | Date/Time Prepared: | 5/29/2018 9:58 am

In Lieu of Form CMS-2552-10

					5/29/2018 9:5	8 am
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED			0 0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0		0 0	0	0	26. 00
27. 00 NURSE PRACTITIONER	12		0 12	0	12	27. 00
28. 00 REGI STERED NURSE	131		0 131	0	131	28. 00
29. 00 LPN/LVN	0		0 0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0		0 0	0	0	30. 00
31. 00 OCCUPATI ONAL THERAPY	0		0 0	0	0	31. 00
32.00 SPEECH/LANGUAGE PATHOLOGY	0		0 0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	37		0 37	0	37	33. 00
34. 00 SPI RI TUAL COUNSELI NG	0		0 0	0	0	34.00
35. 00 DI ETARY COUNSELING	0		0 0	0	0	35. 00
36. 00 COUNSELING - OTHER	0		0 0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	37		0 37	0	37	37. 00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0		0 0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0		0 0	0	0	39. 00
40.00 I MAGING SERVICES	0		0 0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0		0 0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0		0 0	0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0		0 0	0	0	42. 50
43.00 OUTPATIENT SERVICES	0		0 0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0		0 0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0		0 0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0		0 0	0	0	46. 00
100. 00 TOTAL *	217		0 217	0	217	100.00
* Transfer the amount in column 7 to Wkst 0-5 col	ump 1 lino 52					

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

DIRECT PATIENT CARE SERVICE COST CENTERS						
DI RECT PATIENT CARE SERVICE COST CENTERS			ADJUSTMENTS			
DI RECT PATIENT CARE SERVICE COST CENTERS 25.00 1NPATIENT CARE -CONTRACTED 0 0 0 25.00 26.00 27.00 NURSE PRACTITIONER 0 12 27.00 28.00 REGI STERED NURSE 0 131 28.00 29.						
25. 00 INPATIENT CARE-CONTRACTED 0 0 25. 00 26. 00 PHYSI CI AN SERVI CES 0 0 0 26. 00 27. 00 NUNSE PRACTITI ONER 0 12 27. 00 28. 00 REGI STERED NURSE 0 131 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 37 32. 00 34. 00 SPI RI TUAL COUNSELI ING 0 0 34. 00 35. 00 DI ETARY COUNSELI ING 0 0 35. 00 36. 00 COUNSELI ING - O THER 0 0 36. 00 37. 00 HOSPI CE AL IDE & HOMEMAKER SERVI CES 0 37 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00		T	6. 00	7. 00		
26. 00 PHYSI CI AN SERVI CES 0 0 12 26. 00 27. 00 NURSE PRACTI TI ONER 0 12 27. 00 28. 00 REGI STERED NURSE 0 131 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPECH/LANGIGACE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 37 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 35. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 37 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 0 40. 00 IMAGI NG SERVI CES 0 0 0 41. 00 LABS & DI AGNOSTI			_			
27. 00 NURSE PRACTITIONER 0 12 27. 00 28. 00 REGI STERED NURSE 0 131 28. 00 29. 00 LPM/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATIONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 31. 00 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 37 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 35. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 37 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGI ING SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42	25.00	I NPATIENT CARE-CONTRACTED	0	0		
28. 00 REGISTERED NURSE 0 131 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SCRI L SERVI CES 0 37 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 37 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 LABS & DI AGNOSTI CS 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50	26.00		0	0		26.00
29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 37 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 35. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 37 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGIN SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES0 0 42. 50 <	27. 00	NURSE PRACTITIONER	0	12		27. 00
30.00 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00	REGI STERED NURSE	0	131		28.00
31.00 OCCUPATIONAL THERAPY 0 0 0 0 0 32.00 32.00 32.00 33.00 MEDICAL SOCIAL SERVICES 0 0 37 33.00 34.00 35.00 DIETARY COUNSELING 0 0 0 34.00 35.00 DIETARY COUNSELING 0 0 0 35.00 0 0 35.00 0 0	29.00	LPN/LVN	0	0		29.00
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 37 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 37 37 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	PHYSI CAL THERAPY	0	0		30.00
33. 00 MEDI CAL SOCI AL SERVI CES 30 SPIRI TUAL COUNSELING 31. 00 DI ETARY COUNSELING 35. 00 DI ETARY COUNSELING 36. 00 COUNSELING 0 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 37. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 0 40. 00 IMAGI NG SERVI CES 0 0 41. 00 LABS & DI AGNOSTI CS 0 0 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 OUTPATI ENT SERVI CES 0 0 43. 00 OUTPATI ENT SERVI CES 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0	31.00	OCCUPATI ONAL THERAPY	0	0		31.00
34. 00 SPIRITUAL COUNSELING 0 0 0 33. 00 35. 00 DI ETARY COUNSELING 0 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 37 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 41. 00 41. 00 LABS & DI AGNOSTICS 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 0 42. 50 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46. 00	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
35.00 DI ETARY COUNSELING 0 0 0 0 35.00 36.00 36.00 37.00 36.00 37.00 40.50 40.00	33.00	MEDICAL SOCIAL SERVICES	0	37		33.00
36. 00 COUNSELING - OTHER 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 37 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 40. 00 41. 00 LABS & DI AGNOSTICS 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42. 00 42. 50 DRUGS CHARGED TO PATIENTS 0 0 42. 00 43. 00 OUTPATIENT SERVICES 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46. 00	34.00	SPIRITUAL COUNSELING	0	0		34.00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 37 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 39. 00 PATIENT TRANSPORTATION 0 0 0 40. 00 IMAGING SERVICES 0 0 0 41. 00 LABS & DIAGNOSTICS 0 0 0 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 43. 00 OUTPATIENT SERVICES 0 0 0 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0	35.00	DI ETARY COUNSELI NG	0	0		35.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTICS 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 0 42. 50 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46. 00	36.00	COUNSELING - OTHER	0	0		36.00
39. 00 PATIENT TRANSPORTATION 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTICS 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46. 00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	37		37.00
40. 00 IMAGING SERVICES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTICS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTINE 0 0 0 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 43. 00 OUTPATIENT SERVICES 0 0 0 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 47. 00 0 0 48. 00 0 0 49. 00 40. 00 0 0 40. 00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
41.00 LABS & DI AGNOSTI CS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43.00 OUTPATI ENT SERVI CES 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44.00 45.00 PALLI ATI VE CHEMOTHERAPY 0 0 45.00 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46.00	39.00	PATI ENT TRANSPORTATION	0	0		39.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46. 00	40.00	I MAGI NG SERVI CES	0	0		40.00
42. 50 DRUGS CHARGED TO PATIENTS 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46. 00	41.00	LABS & DIAGNOSTICS	0	0		41.00
43.00 OUTPATIENT SERVICES 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	43.00	OUTPATIENT SERVICES	0	0		43.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
	45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
100.00 TOTAL * 0 217 100.00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
	100.00	TOTAL *	0	217		00.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

 Heal th Financial Systems
 PARKVIEW WABASH HOSPITAL, INC.

 ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
 Provider C
 Provider CCN: 15-1310 Peri od: Worksheet 0-4 From 01/01/2017 To 12/31/2017 INPATIENT CARE Date/Time Prepared: 5/29/2018 9:58 am Hospi ce CCN: 15-1545

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	43	0	43	0	43	27. 00
28.00	REGI STERED NURSE	473	0	473	0	473	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	135	0	135	0	135	33. 00
34.00	SPIRITUAL COUNSELING	O	0	0	o	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	133	0	133	o	133	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	o	0	0	o	0	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	o	0	42. 50
43.00	OUTPATIENT SERVICES	o	0	0	o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	l	0	0	o	0	46. 00
	TOTAL *	784	0	784	o	784	100.00
	ofor the amount in column 7 to Wkst 0 E colu	ump 1 lino E2					

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	1			
	INPATIENT CARE-CONTRACTED	0	0		25. 00
	PHYSI CI AN SERVI CES	0	0		26. 00
	NURSE PRACTITIONER	0	43		27. 00
	REGI STERED NURSE	0	473		28. 00
29. 00	LPN/LVN	0	0		29. 00
	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	135		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	133		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	o		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	o		42.50
43.00	OUTPATIENT SERVICES	0	o		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	o		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o		46.00
	TOTAL *	0	784		100.00
	6 11 1 7 1 10 0 5 1				

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems PARKVIEW WABASH H	OSPLTAL LNC		In lie	eu of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der Co		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2017		
		Hospi ce CCI	N: 15-1545	To 12/31/2017	Date/Time Pre 5/29/2018 9:5	bared: 8 am
				Hospi ce I		
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)		1 + 2)	
				WKST B PART I		
				(see		
			1 00	instructions)		
	OFFICE ALL OFFICE OF ACCUTANCE OF A CONTROL		1.00	2. 00	3. 00	
4 00	GENERAL SERVICE COST CENTERS		1			4 00
1.00	CAP REL COSTS-BLDG & FIXT			0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			17, 391	17, 391	3.00
4.00	ADMI NI STRATI VE & GENERAL		97, 04	92, 216	189, 264	4.00
5.00	PLANT OPERATION & MAINTENANCE			0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE			0	0	6. 00
7.00	HOUSEKEEPI NG			0	0	7. 00
8.00	DI ETARY			0	0	8. 00
9.00	NURSING ADMINISTRATION			0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		1, 42	7 383	1, 810	10.00
11. 00	MEDI CAL RECORDS			0	0	11. 00
12.00	STAFF TRANSPORTATION		6, 82	4	6, 824	12.00
13.00	VOLUNTEER SERVICE COORDINATION			O	0	13.00
14.00	PHARMACY		11, 56	2 0	11, 562	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			O	0	15. 00
16.00	OTHER GENERAL SERVICE			0 (0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17. 00
	LEVEL OF CARE					

	<i>J</i>	ANKVIEW WADASH II			III LI C	u or rorm cws	2332-10
COST A	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			'			5/29/2018 9:5	8 am
					Hospi ce I		
	Descriptions	TOTAL EXPENSES C			.E EMPLOYEE	SUBTOTAL	
			FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	17, 391	0		0 17, 391		3. 00
4.00	ADMINISTRATIVE & GENERAL	189, 264	0		0 8, 017	197, 281	
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6. 00
7.00	HOUSEKEEPI NG	0	0		0 0	0	7. 00
8.00	DI ETARY	0	0		0 0	0	8. 00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	1, 810	0		0 0	1, 810	10.00
11.00	MEDI CAL RECORDS	0	0		0	0	11.00
12.00	STAFF TRANSPORTATION	6, 824	0		0 0	6, 824	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	O	0		0 0	0	13.00
14.00	PHARMACY	11, 562	0		0 0	11, 562	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	O	0		0 0	0	15. 00
16.00	OTHER GENERAL SERVICE	o	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17. 00
	LEVEL OF CARE	<u> </u>				•	
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	56, 887			9, 212	66, 099	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	217	0		0 35	252	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	784	0		0 127	911	
	NONREI MBURSABLE COST CENTERS		-		-1		
60.00	BEREAVEMENT PROGRAM	O	0		0 0	0	60.00
61. 00	VOLUNTEER PROGRAM	o	0		0 0	0	1
62.00	FUNDRAI SI NG	o	0		0 0	0	62, 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0 0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM		0		0	0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES		0		0 0	o o	65. 00
66. 00	RESI DENTI AL CARE		0			o o	66.00
67. 00	ADVERTI SI NG		0			l ő	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0			Ö	1
69. 00	THRIFT STORE		0			0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		J			0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)		0		0	0	71.00
99. 00	NEGATIVE COST CENTER		0				99.00
100.00		284, 739	0		0 17, 391	284, 739	
100.00	TIOME	204, 737	O	I	0 17, 371	1 207, 737	1100.00

COST A	ILLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS		CN: 15-1310 N: 15-1545	Peri od: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
						5/29/2018 9:5	8 am
	Descriptions	ADMI NI STRATI VE	DLANT	I ALINIDDY 0	Hospi ce I	DIETADY	
	Descriptions	& GENERAL	PLANT OPERATION &	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	MAI NTENANCE	LINEN SERVIC	E		
		4.00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL	197, 281					4. 00
5. 00	PLANT OPERATION & MAINTENANCE	177,201	0				5. 00
6. 00	LAUNDRY & LINEN SERVICE		0		0		6. 00
7. 00	HOUSEKEEPI NG		0		0		7. 00
8. 00	DI ETARY		0		0	0	1
9. 00	NURSING ADMINISTRATION		0		0	٥	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	4, 083	0		0		10.00
11. 00	MEDICAL RECORDS	4,003	0		0		11.00
12. 00	STAFF TRANSPORTATION	15, 393	0		0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	15, 373	0		0		13. 00
14. 00	PHARMACY	26, 081	0		0		14. 00
15. 00	PHYSI CI AN ADMINISTRATI VE SERVI CES	20,001	0		0		15. 00
16. 00	OTHER GENERAL SERVICES	0	0		0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
17.00	LEVEL OF CARE	J U	U	'\	0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	l ol					50.00
51. 00	HOSPICE ROUTINE HOME CARE	149, 101					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	568	0		0 0	0	1
53. 00	HOSPICE GENERAL INPATIENT CARE	2, 055	0	l	0 0		1
55.00	NONREI MBURSABLE COST CENTERS	2,033		′1	0 0		33.00
60.00	BEREAVEMENT PROGRAM	0	0)	0		60.00
61. 00	VOLUNTEER PROGRAM		0		0		61. 00
62. 00	FUNDRAI SI NG		0		0		62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		0		63. 00
64. 00	PALLIATIVE CARE PROGRAM		0		0		64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0		65. 00
66. 00	RESI DENTI AL CARE		0			0	
67. 00	ADVERTI SI NG		0			٥	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0		0		68. 00
69. 00	THRIFT STORE		0		0		69. 00
70. 00	NURSING FACILITY ROOM & BOARD	١	0	ή	0		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0			0	
99. 00	NEGATIVE COST CENTER		0			· -	
	TOTAL	197, 281	0			-	100.00
100.00	TOTAL	171, 201	U	′1	ο ₁ 0	1	1100.00

Heal th	Financial Systems P	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provi der Co	CN: 15-1310	Peri od:			
				From 01/01/2017			
			Hospi ce CCI	N: 15-1545	To 12/31/2017	Date/Time Pre	pared:
					11! 1	5/29/2018 9:5	8 am
	D 111	NUIDCLNIC	DOUTLNE	MEDION	Hospi ce I	VOLUNTEED	
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG			•			7. 00
8. 00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	5, 893		_		10.00
11. 00	MEDI CAL RECORDS	0			0		11. 00
12. 00	STAFF TRANSPORTATION	0			22, 217		12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13. 00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	0			0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	•					İ
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	5. 761		0 21, 829	0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	22		0 85	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE		110		0 303	0	53. 00
33. 00	NONREI MBURSABLE COST CENTERS	1 9	110		0 303		33.00
60.00	BEREAVEMENT PROGRAM	O			0	0	60.00
					0	0	
61.00	VOLUNTEER PROGRAM	0			0		61.00
62.00	FUNDRAL SI NG	0			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	0			0	0	66. 00
67.00	ADVERTI SI NG	0			0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69.00	THRI FT STORE	0			0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREI MBURSABLE (SPECIFY)				0	0	71.00
99. 00	NEGATIVE COST CENTER		Ω		0 0	0	99.00
	TOTAL		5, 893		0 22, 217	-	100.00
100.00	// TOTALE	١	3, 073	ı	22, 217	O	1100.00

Health Financial Systems	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSTS	Provi der CCI		eri od:	Worksheet 0-6	
			F	rom 01/01/2017	Part I	
		Hospi ce CCN	: 15-1545 T	o 12/31/2017	Date/Time Pre	
					5/29/2018 9:5	8 am
				Hospi ce I		
Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
		SERVI CES		CARE SERVICES		
	14.00	15. 00	16. 00	17. 00	18. 00	
GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2. 00
3.00 EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00 ADMINISTRATIVE & GENERAL						4. 00
5.00 PLANT OPERATION & MAINTENANCE						5. 00
6.00 LAUNDRY & LINEN SERVICE						6.00
7. 00 HOUSEKEEPI NG						7. 00
8. 00 DI ETARY						8. 00
						1
9.00 NURSING ADMINISTRATION	1					9. 00
10.00 ROUTINE MEDICAL SUPPLIES						10.00
11.00 MEDICAL RECORDS						11. 00
12.00 STAFF TRANSPORTATION						12.00
13.00 VOLUNTEER SERVICE COORDINATION	i i					13.00
14. 00 PHARMACY	37, 643					14. 00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES	37,043	0				15. 00
	0	٩	0			
16. 00 OTHER GENERAL SERVICE	ı o		0	_		16. 00
17. 00 PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
LEVEL OF CARE						
50.00 HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00 HOSPICE ROUTINE HOME CARE	36, 989	0	0		279, 779	51.00
52.00 HOSPICE INPATIENT RESPITE CARE	142	o	0	o	1, 069	52. 00
53.00 HOSPICE GENERAL INPATIENT CARE	512	o	0	o	3, 891	
NONREI MBURSABLE COST CENTERS	, ,,,,	91		٥	3, 3, 1	1 00.00
60. 00 BEREAVEMENT PROGRAM	0		0		0	60.00
			0		0	
			0		-	61.00
62. 00 FUNDRAI SI NG	O		0		0	62. 00
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63. 00
64.00 PALLIATIVE CARE PROGRAM	0		0		0	64.00
65. 00 OTHER PHYSICIAN SERVICES	o		0		0	65. 00
66. 00 RESI DENTI AL CARE	0	0	0	o	0	66.00
67. 00 ADVERTI SI NG		Ĭ	0	Ĭ	0	67. 00
68. 00 TELEHEALTH/TELEMONI TORI NG			0		0	68. 00
			0		-	
69. 00 THRIFT STORE	١		0		0	69. 00
70.00 NURSING FACILITY ROOM & BOARD					0	70. 00
71.00 OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71. 00
99.00 NEGATIVE COST CENTER		0	0	0	0	99. 00
100. 00 TOTAL	37, 643	o	0	o	284, 739	100.00
·				1	-	•

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CCN: 15-1310	Peri od:	Worksheet 0-6
STATISTICAL BASIS			From 01/01/2017	Part II

Hospi ce CCN: 15-1545 To 12/31/2017 Date/Time Prepared: 5/29/2018 9:58 am Hospi ce I CAP REL BLDG & CAP REL MVBLE **EMPLOYEE** RECONCI LI ATI ON ADMI NI STRATI VE Cost Center Descriptions BENEFITS EQUI P & GENERAL FIX (SQUARE FEET) (DOLLAR VALUE) DEPARTMENT (ACCUMULATED COSTS) (GROSS SALARI ES) 1.00 2.00 4A 4.00 3.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 18, 268 3.00 000000000000000 ADMINISTRATIVE & GENERAL 8, 421 -197, 281 87, 458 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 Λ 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 7.00 0 8.00 DI ETARY 0 0 8.00 0 NURSING ADMINISTRATION 0 0 9.00 Ω 9.00 10.00 ROUTINE MEDICAL SUPPLIES 0 1, 810 10.00 MEDICAL RECORDS 0 11.00 0 0 11.00 0 STAFF TRANSPORTATION 0 6, 824 12 00 12 00 0 13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00 PHARMACY 0 0 14.00 0 11, 562 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15 00 Ω 15 00 0 OTHER GENERAL SERVICE 16.00 C 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50 00 O 0 50 00 0 0 66, 099 51.00 HOSPICE ROUTINE HOME CARE 9,677 51.00 HOSPICE INPATIENT RESPITE CARE 0 37 0 252 52.00 52.00 911 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 133 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 0 0 60.00 VOLUNTEER PROGRAM 00000000 0 0 0 61.00 0 0 0 0 0 0 0 0 61.00 FUNDRAI SI NG 0 0 62.00 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 0 64.00 OTHER PHYSICIAN SERVICES 0 65.00 65.00 RESIDENTIAL CARE 0 66.00 0 66.00 0 0 67.00 ADVERTI SI NG 0 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 THRIFT STORE 0 0 69.00 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71.00 0 71.00 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 17, 391 197, 281 100. 00

0.000000

0.000000

0. 951993

2. 255723 101. 00

101.00 UNIT COST MULTIPLIER

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provi der CCN: 15-13 Hospi ce CCN: 15-1	10 Period: From 01/01/2017 To 12/31/2017	
			Hospi ce I	

			Hospi ce CC	N: 15-1545 T	o 12/31/2017	Date/Time Pre 5/29/2018 9:5	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY	,	DAYS)		
		(SQUARE FEET)	DAYS)			(DIRECT NURS.	
		(/			HRS.)	
		5. 00	6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS		0.00	7.00	0.00	7, 00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
				΄			7.00
7.00	HOUSEKEEPI NG	0					
8.00	DI ETARY	0		0	U		8. 00
9. 00	NURSI NG ADMI NI STRATI ON	0		0		0	
10. 00	ROUTINE MEDICAL SUPPLIES	0	1	0		0	
11. 00	MEDI CAL RECORDS	0		0		0	1
12. 00	STAFF TRANSPORTATION	0		0		0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16.00	OTHER GENERAL SERVICE	0		0		l 0	16, 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE			-	II.		1
50.00	HOSPI CE CONTI NUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					l o	
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0) 0	0		
53. 00	HOSPICE GENERAL INPATIENT CARE			1	0	0	
55.00	NONREI MBURSABLE COST CENTERS			<u>, </u>	0		33.00
60. 00	BEREAVEMENT PROGRAM	0	ı			0	60.00
61. 00	VOLUNTEER PROGRAM					0	
62. 00	FUNDRAI SI NG					0	
		0				-	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	
65. 00	OTHER PHYSI CI AN SERVI CES	0		0		0	
66. 00	RESI DENTI AL CARE	0	0) 0	0	0	
67. 00	ADVERTI SI NG	0		0		0	
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRI FT STORE	0		0		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99. 00	NEGATIVE COST CENTER	1					99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	1) 0	0	0	0	0	100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	0. 000000		
	1	1 2.230000	1 2.22000	1	1 2123000	1 2:223000	1

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE G	ENERAL SERVICE COSTS	Provider CCN: 15-1310		Worksheet 0-6
STATISTICAL BASIS			From 01/01/2017	Part II

STATISTICAL BASIS Hospi ce CCN: 12/31/2017 Date/Time Prepared: 15-1545 To 5/29/2018 9:58 am Hospi ce I ROUTI NE MEDI CAL STAFF VOLUNTEER PHARMACY Cost Center Descriptions RECORDS MEDI CAL TRANSPORTATI ON SERVI CE (CHARGES) SUPPLI ES (PATIENT DAYS) COORDI NATI ON (PATIENT DAYS) (MI LEAGE) (HOURS OF SERVICE) 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 1, 345 10.00 MEDICAL RECORDS 11.00 11.00 STAFF TRANSPORTATION 12.00 6,825 12 00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 PHARMACY 0 0 315, 275 14.00 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15 00 0 OTHER GENERAL SERVICE 16.00 0 0 0 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50 00 n O 0 50 00 0 HOSPICE ROUTINE HOME CARE 0 309, 799 51.00 1, 315 0 6,706 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 0 26 0 1, 190 52.00 93 53.00 HOSPICE GENERAL INPATIENT CARE 25 0 0 4, 286 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 0 61.00 61.00 0 0 0 0 0 0 0 FUNDRAI SI NG 0 62.00 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 63.00 0 0 64.00 PALLIATIVE CARE PROGRAM 0 64.00 OTHER PHYSICIAN SERVICES 0 65.00 65.00 RESIDENTIAL CARE 0 66.00 0 66.00 0 ADVERTI SI NG 67.00 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 THRIFT STORE 0 o 69.00 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71.00 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 5, 893 22, 217 37, 643 100. 00

4. 381413

0.000000

3. 255238

0.000000

0. 119397 101. 00

101.00 UNIT COST MULTIPLIER

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE	GENERAL SERVICE COSTS	Provider CCN: 15-1310	Peri od:	Worksheet 0-6
STATISTICAL BASIS			From 01/01/2017	
STATESTICAL BASES		Hospi co CCN: 15-15/5		Date/Time Prepared

			Hospi ce CC	N: 15-1545	To 12/31/2017		
					Hospi ce I	5/29/2018 9:	. 30 alli
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/	1103pr ce 1		
	oust defiter bescriptions	ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)		(IN-FACILITY			
		(FAITENI DAIS)	DASI 3)		•		
		15. 00	16.00	DAYS) 17.00	_		
	CENEDAL CEDVICE COST CENTEDS	15.00	16.00	17.00			
1 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT		I	I			1 00
1.00							1.00
2.00	CAP REL COSTS-MVBLE EQUIP	•					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY						14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
	OTHER GENERAL SERVICE						16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		٥	Ί	0		17. 00
17.00	LEVEL OF CARE				<u>ol</u>		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	d .			50.00
51. 00	HOSPICE CONTINUOUS HOME CARE		-				51.00
	HOSPICE INPATIENT RESPITE CARE			1	0		52.00
53. 00				l .	0		53. 00
55.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS			1	U		33.00
60. 00	BEREAVEMENT PROGRAM		0				60, 00
				l .			
61.00	VOLUNTEER PROGRAM			1			61.00
62.00	FUNDRAI SI NG	•		1			62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	1			63. 00
64. 00	PALLIATIVE CARE PROGRAM		0	1			64. 00
65. 00	OTHER PHYSICIAN SERVICES		0	1			65. 00
66. 00	RESI DENTI AL CARE	0	0		0		66. 00
67. 00	ADVERTI SI NG		0)			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	1			68. 00
69. 00	THRI FT STORE		0)			69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0)	0		71. 00
99.00	NEGATIVE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, F	Part I) 0	0		0		100.00
	UNIT COST MULTIPLIER	0.000000	0. 000000	0. 00000	00		101.00
	1	1	1	'	'		

Heal th	Financial Systems PA	ADKVIEW WARASH H	OSDITAL INC		In lie	eu of Form CMS-2	2552_10
	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV		Provi der Co	CN: 15-1310	Peri od:	Worksheet 0-7	
	OF CARE			N: 15-1545	From 01/01/2017 To 12/31/2017		pared:
					Hospi ce I	0,2,7,2010 7.0	<u>o am</u>
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C	ost to Chargo	HCHC	HRHC	HI RC	
	cost center bescriptions	Part I, Col. 9	Ratio	TICHE	TIKTIC	III KC	
		line	Ratio				
		0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS				<u> </u>		
1.00	PHYSI CAL THERAPY	66. 00	0. 475115		0 0	0	1. 00
2.00	OCCUPATI ONAL THERAPY	67. 00	0. 608112		0 0	0	
3.00	SPEECH PATHOLOGY	68. 00	1. 692450		0 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 278454		0 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6.00	LABORATORY	60.00	0. 175990		0 0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 315989		0 0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9.00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76. 00					10.00
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
		Records)					
	Cost Center Descriptions	HGI P H			xHIRC (col. 1 x		
		F 00	col . 2)	col . 3)	col . 4)	col . 5)	
	ANCILLARY SERVICE COST CENTERS	5.00	6. 00	7. 00	8. 00	9. 00	
1. 00	PHYSI CAL THERAPY		0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY		0			0	
3.00	SPEECH PATHOLOGY		0			0	
4. 00	DRUGS CHARGED TO PATIENTS		0			0	
4.00	DRUGG CHARGED TO PATTENTS	١	U		9	1	4.00

0

0

0

5.00

6. 00 7. 00

8.00

9.00

10.00 0 11.00

5.00

6.00

7. 00 8.00

9.00

DURABLE MEDICAL EQUIP-RENTED

10.00 OTHER ANCILLARY SERVICE COST CENTERS
11.00 Totals (sum of lines 1-11)

RADI OLOGY-THERAPEUTI C

LABORATORY
MEDICAL SUPPLIES CHARGED TO PATIENT
OTHER OUTPATIENT SERVICE COST CENTER

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	11	n Lieu of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PE	R DIFM COST	Provider CCN: 15-1310	Peri od:	Worksheet 0-8

Provi der CCN: 15-1310 | Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 9:58 am Hospi ce I

			Hospi ce I		
		TITLE XVIII	TITLE XIX	TOTAL	
		MEDI CARE	MEDI CAI D		
		1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6,			0	1. 00
	line 11)				
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	ol		4. 00
5.00	Program cost (line 3 times line 4)	0	ol		5. 00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7,			279, 779	6.00
	line 11)				
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			1, 315	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)			212. 76	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	1, 301	14		9. 00
10.00		276, 801	2, 979		10.00
	HOSPICE INPATIENT RESPITE CARE	<u> </u>	· .		
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8,			1, 069	11. 00
	line 11)				
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			213. 80	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	o		14.00
15.00	Program cost (line 13 times line 14)	1, 069	o		15. 00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9,			3, 891	16. 00
	line 11)				
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			25	17. 00
18.00	Total average cost per diem (line 16 divided by line 17)			155. 64	18. 00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	18	7		19. 00
20.00	Program cost (line 18 times line 19)	2, 802	1, 089		20. 00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			284, 739	21. 00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			1, 345	22. 00
23.00	Average cost per diem (line 21 divided by line 22)			211. 70	23. 00
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