payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1310
AND SETTLEMENT SUMMARY

Period:
From 01/01/2018
To 12/31/2018
Date/Time Prepared:
A(27/2020 11-05 em.)

7.110 SETTEEMENT			To 12/31/2018	Date/Time F 4/27/2020	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed cost report		Date: 4/27/20	20 Time:	11:05 am
use only	2. [] Manually submitted cost report				
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "L" $^{\circ}$		resubmitted this co	ost report	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	r this Provider CCN 12.	NPR Date: Contractor's Vendo [O]If line 5, co number of tim	olumn 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 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

SVP/CF0

Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-358, 295	796, 062	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	-38, 171	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	o	0		0	9. 00
200.00	Total	0	-396, 466	796, 062	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.

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Enter in column 1, "Y" for yes or "N" for no, for the portion of the		22.02							
+									
cost reporting period prior to October 1. Enter in column 2, "Y" for yes									
or "N" for no, for the portion of the cost reporting period on or after October 1.									
22.03 Did this hospital receive a geographic reclassification from urban to N N	N	22. 03							
rural as a result 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 N		23. 00							
below? In column 1, enter 1 if date of admission, 2 if census days, or 3		23.00							
if date of discharge. Is the method of identifying the days in this cost									
reporting period different from the method used in the prior cost									
reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medic	caid Other								
Medicaid Medicaid State State HMO of									
paid days eligible Medicaid Medicaid	days								
unpaid paid days eligible									
days unpai d 1.00 2.00 3.00 4.00 5.0	00 6.00	-							
24. 00 If this provider is an IPPS hospital, enter the		0 24.00							
in-state Medicaid paid days in column 1, in-state		1							
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.	S								

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	:N: 15-1310	Period From (/2018	Works Part	sheet S-2 I	
						/2018	4/27/	Time Pre/2020 11:	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-o State Medica eligib	d e	Medica HMO da		Other ledi cai d days	
	1. 00	2. 00	3. 00	unpai 4. 00	d	5. 00		6. 00	
5.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0			0 0		0	of Geogr	25. C
					1. 00			2. 00	
 6.00 Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for 7.00 Enter your standard geographic classification (not was reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification. 5.00 If this is a sole community hospital (SCH), enter the 	rural. age) status "2" for ru cation in o	at the end ural. If ap column 2.	l of the cos oplicable,	it		2 2			26. 0 27. 0 35. 0
effect in the cost reporting period.				Ве	gi nni	ng:	En	di ng:	
6.00 Enter applicable beginning and ending dates of SCH st	tatus Subs	crint line	36 for numb		1. 00			2. 00	36. 0
of periods in excess of one and enter subsequent date	es.	·							
7.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for the		·		IS		0			37.0
accordance with FY 2016 OPPS final rule? Enter "Y" foinstructions) 8.00 If line 37 is 1, enter the beginning and ending dates	,								38.0
greater than 1, subscript this line for the number of enter subsequent dates.					Y/N			Y/N	30. 0
					1. 00			2. 00	
9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 0.00 Is this hospital subject to the HAC program reduction), (ii), or the mileage i)? Enter i	(iii)? Ent requiremen n column 2	er in colum nts in ?"Y" for ye	nn es	N N			N N	39. C
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	"Y" for y			IN	V	VVII		40. 0
						1. 00	XVI 2. C		
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital paymen	nt for disn	conorti onat	a shara in	accorda	200	N	N	N	45. C
with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment exce	eption for e	extraordi na	ıry circumst	ances		N	N	N	46. 0
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	ı and Wkst	. L-1, Pt.	ı throu	gh				
7.00 Is this a new hospital under 42 CFR §412.300(b) PPS c 8.00 Is the facility electing full federal capital payment Teaching Hospitals			,		•	N N	N N	N N	47. C 48. C
6.00 Is this a hospital involved in training residents in or "N" for no.	approved GI	ME programs	? Enter "Y	‴ for y	es	N			56.0
7.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N' th of this of (", completo , if applio	'for no in cost report Worksheet cable.	n column 1. ing period? : E-4. If co	If colu P Enter Ulumn 2	mn 1 "Y"				57. (
8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as					58.0
9.00 Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N		kshe Li ne	#	Qual i	-Through fication rion Code	59. C
									1
0.00 Are you claiming nursing and allied health education	(MALIES		1. 00 N		2.00)	:	3. 00	60. (

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu of For						2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CO	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet S-2 Part I Date/Time Pre 4/27/2020 11:0	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
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. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Dro	ogram Namo	Drogram Codo	Unweighted IME	Upwei abted	61. 06
	PI	ogram Name	Program Code		Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0. 00		61. 10
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of FTE residents that rotated from a funcion of the post post post of FTE residents.	ti ons) Teachi	ng Health Cen	ter (THC) into			62. 00 62. 01
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se	er Sett ettings	ings during this co	ost reporting p		N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple	C IIII	os of through	Unwei ghted		Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
	1.00 2.00					
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	•		This base year	is your cost r	eporti ng	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y train -priman all non non-pn column	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 4/27/2020 11:05 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 ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	instructions) Enter "Y" for yes or "N" for no in the applica	ble column.	, , , , , , , , , , , , , , , , , , , ,			
93.00			d XIX? Enter	N	N	93. 00
70.00	"Y" for yes or "N" for no in the applicable column.	o		••		70.00
94. 00		and "N" for r	n in the	N	N	94. 00
74.00	applicable column.	and N 101 1	io i ii tiic	14		74.00
95. 00		dicable colum	nn	0. 00	0.00	95. 00
96. 00				0. 00 N	0.00 N	96. 00
90.00	1 9	OI N IOI I	io i ii tile	IV	IN IN	70.00
07.00	applicable column.	1:		0.00	0.00	07.00
	If line 96 is "Y", enter the reduction percentage in the app			0. 00	0.00	97. 00
98. 00				Υ	Y	98. 00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	for yes or "N"	for no in			
	column 1 for title V, and in column 2 for title XIX.					
98. 01	Does title V or XIX follow Medicare (title XVIII) for the re			Υ	Υ	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in	column 2 for			
	title XIX.					
98. 02	Does title V or XIX follow Medicare (title XVIII) for the ca	lculation of	observati on	Υ	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	r "N" for no	in column 1			
	for title V, and in column 2 for title XIX.					
98. 03	Does title V or XIX follow Medicare (title XVIII) for a crit	ical access h	ospital (CAH)	N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye	s or "N" for	no in column 1			
	for title V, and in column 2 for title XIX.					
98. 04		reimbursed 10	1% of	N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in			• •		
	in column 2 for title XIX.					
98. 05		ck the RCE di	sallowance on	Υ	Υ	98. 05
70. 03	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				'	70.03
	column 2 for title XIX.	or allin i i or i	ittic v, and in			
98. 06		ur Wket D	Υ	Υ	98. 06	
90.00	Pts. I through IV? Enter "Y" for yes or "N" for no in column			ī	T T	96.00
		i i ioi titie	v, and in			
	column 2 for title XIX.					-
405.00	Rural Providers			.,	1	
	Does this hospital qualify as a CAH?			Y		105. 00
106.00	olf this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of payment	N		106. 00
	for outpatient services? (see instructions)					
107.00	olf this facility qualifies as a CAH, is it eligible for cost			N		107. 00
	training programs? Enter "Y" for yes or "N" for no in column					
	yes, the GME elimination is not made on Wkst. B, Pt. I, col.	25 and the p	rogram is cost			
	reimbursed. If yes complete Wkst. D-2, Pt. II.					
108.00	Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 42	N		108. 00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
		Physi cal	Occupati onal	Speech	Respi ratory	
		1.00	2.00	3. 00	4.00	
109.00	Olf 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 ves or "N" for no for each therapy.					
	for yes or "N" for no for each therapy.					
	for yes or "N" for no for each therapy.				1 00	-
110.00		J. Domonetrati	on project (841)	04	1. 00	110.00
110.00	Did this hospital participate in the Rural Community Hospita				1. 00 N	110. 00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter "	Y" for yes or	"N" for no. If	yes,		110. 00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110. 00
110. 00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter "	Y" for yes or	"N" for no. If	yes,		110. 00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110. 00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110.00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110.00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110. 00
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor	Y" for yes or	"N" for no. If	yes,		110.00

Health Financial Systems PARKVIEW WABASH HC HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	OSPITAL, INC. Provider CCN:	15-1310	Peri od:		Worksheet S-	-2552-1 -2
TOOLT THE THIRD HOST THE HEALTH GIVE GOIN EEX TRENTITION ONLY	Trovider con.		From 01/01, To 12/31,		Part I Date/Time Pr 4/27/2020 11	epared:
			1.00	1	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting per umn 1 is Y, ent ticipating in co	riod? Enter er the Jumn 2.	N		2.00	111.00
				1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	If column 2 is t for long term s) based on the	"E", enter care (incl definition	in column udes	N	0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" f 117.00 Is this facility legally-required to carry malpractice insura no.			"N" for	N N		116. 00
118.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if	the policy	is	0		118. 0
		Premi ums	Losse	S	Insurance	
		1. 00	2.00)	3.00	
118.01 List amounts of malpractice premiums and paid losses:		66, 7	29	0	76, 6	12 118. 0
			1. 00		2.00	
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119.00 DO NOT USE THIS LINE			N			118. 0
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" falifies for the	for yes or Outpatient			N	120. 0
121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices c	charged to	Y			121. 0
122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.						122. 0
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	ves and "N" fo	or no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, ent	ter the certific	ation date				126. 0
in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, ente		ntion date				127. 0
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, ente		ntion date				128. 0
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter		ion date i	n			129. 0
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, e	enter the certif	cation				130. 0
date in column 1 and termination date, if applicable, in colu 131.00 f this is a Medicare certified intestinal transplant center,	enter the cert	i fi cati on				131. 0
date in column 1 and termination date, if applicable, in colu 132.00 If this is a Medicare certified islet transplant center, ente	er the certifica	ntion date				132. 0
in column 1 and termination date, if applicable, in column 2. 133.00 f this is a Medicare certified other transplant center, ente	er the certifica	ntion date				133. 0
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.		column 1				134. 0
All Providers						_
140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	yes, and home of	fice costs	Y			140. 0

	A TRENTITICATION DATA	Frovider CC			1/01/2018	Part I Date/Time Pro 4/27/2020 11:	epared
1.00	2.	00			3. 00	4/2//2020 11.	. 05 alli
If this facility is part of a cha				name and	d address	of the	
home office and enter the home of 141.00 Name: PARKVIEW HEALTH SYSTEM, IN	C. Contractor's Name: W			tor's Nu	mber: 0810	01	141. 0
142.00 Street: 10501 CORPORATE DRIVE		6600					142. 0
143.00 City: FORT WAYNE	State: I	N	Zi p Code	e:	4684	.5	143. 0
						1.00	
144.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144. (
					1.00		
I45.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" I46.00 Has the cost allocation methodolo	" for yes or "N" for no i clude Medicare utilizatio for no in column 2. gy changed from the previ	n column 1. If on for this cost	column 1 is reporting t report?		1. 00 N	2.00	145. (
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub.	15-2, chapter 4	40, §4020) I	f			
						1.00	
147.00 Was there a change in the statist						N	147. (
48.00 Was there a change in the order o 49.00 Was there a change to the simplif				r no		N N	148. (
144.00 was there a change to the shipin	red cost irriding method:	Part A	Part B		itle V	Title XIX	147.
		1.00	2.00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal	N TOT HO TOT EACH COMPO	N N	N N	(366 42	N 9413	N N	155.
56. 00 Subprovi der – TPF		N	N		N	N	156.
57.00 Subprovider - IRF		N	N		N	N	157.
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 159.
60.00 HOME HEALTH AGENCY		N	N		N	N	160.
61. 00 CMHC			N		N	N	161.
						1.00	+
Multicampus							
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more campu	uses in diff	erent CB	SSAs?	N	165.
Eliter 1 for yes of N for no.	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 ffline 165 is yes, for each 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)						0.0	0 166.
						1.00	-
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvestme	nt Act		1.00	
67.00 s this provider a meaningful use 68.00 of this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Enter 05 is "Y") and is a meani HIT assets (see instructi	"Y" for yes or ' ngful user (line ons)	"N" for no. e 167 is "Y"), enter		Y	167. 168.
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	? Enter "Y" for yes or "N	" for no. (see i	instructions)		0.0	168. 0169.
transition factor. (see instructi							1
					gi nni ng	Endi ng	-
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the re	eporti ng		1.00	2.00	170.
					1. 00	2.00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, col	I. 6? Enter		N		0171.

N

19.00

Ν

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

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

Report data for corrections of other PS&R Report

cost report? If yes, see instructions.

information? If yes, see instructions.

Heal th	Financial Systems PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS	-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1310	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S- Part II Date/Time Pr 4/27/2020 11	epared:	
		Descr	i pti on	Y/N	Y/N		
			0	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
		Y/N	Date	Y/N	Date		
	III	1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	HOSPI TALS)				
	Capital Related Cost		,				
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ng the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	yes, submit	N	27. 00			
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	reporting	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00				
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30.00				
	instructions.						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	, see	N	31. 00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnishe	ed through co	ntractual	N	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If	N	33. 00	
	no, see instructions. Provider-Based Physicians						
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physi ci ans?	Υ	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended exilohysicians during the cost reporting period? If yes, see in		nts with the p	orovi der-based	Υ	35. 00	
	This during the cost reporting perrou? IT yes, see In	ISTI UCTI OIIS.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36. 00	Were home office costs claimed on the cost report?			Y		36.00	
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	nome office?	Y		37. 00	
38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00	
39. 00	j ' '			, N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	i nstructi ons.						
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00	
42. 00		PARKVIEW HEALT	TH SYSTEM, INC	C.		42. 00	
43. 00		2603738406		ERI C. NI CKESON@I	PARKVI EW. COM	43. 00	
	report preparer in columns 1 and 2, respectively.					II	

Heal th	Financial Systems PARKVIEW WABASI	H HOSPITAL, INC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1310	Peri od: From 01/01/2018		
			To 12/31/2018	Date/Time Pre 4/27/2020 11:	05 am
		3. 00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	DI RECTOR, REIMBURSEMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

 Heal th Financial
 Systems
 PARKVIEW V

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

					[1	o 12/31/2018	Date/Time Pre 4/27/2020 11:	
							I/P Days / 0/P	
							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		18	7, 809	64, 320. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	
6.00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			18	7, 809	64, 320. 00	0	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)	40.00						12.00
13.00	NURSERY	43. 00		4.0	7 000	/ / 000 00	0	
14.00	Total (see instructions)			18	7, 809	64, 320. 00	l .	
15. 00	CAH visits						0	
16.00	SUBPROVIDER - I PF							16.00
17. 00	SUBPROVIDER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00 20. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	101 00					_	
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	114 00		0				23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00		0	()		24. 00 24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	69.00		18			U	27. 00
28. 00	Observation Bed Days			10			0	
29. 00	Ambul ance Trips						0	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)			0				32.00
32. 00	Total ancillary labor & delivery room			U		΄		32. 00
32. UI	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
30. 01	12.5 5. to hout at days and at sonal ges		ı		I .	T .	ı	, 55. 51

Provider CCN: 15-1310

						4/27/2020 11:	05 am
		I/P Days	/ 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)	1, 143	27	2, 599			1. 00
2.00	HMO and other (see instructions)	807	34				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	30	0	30			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	11			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 173	27	2, 640			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		14	40)		13. 00
14.00	Total (see instructions)	1, 173	41	2, 680	0.00	186. 30	14. 00
15.00	CAH visits	0	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	0	0	(0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	(0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			()		24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
27. 00	Total (sum of lines 14-26)				0.00	186. 30	27. 00
28. 00	Observation Bed Days		7	1, 128	3		28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			ϵ			30. 00
31. 00	1 ' 3			(31. 00
32.00	Labor & delivery days (see instructions)	0	0	19			32. 00
32. 01	Total ancillary labor & delivery room			()		32. 01
	outpatient days (see instructions)						
33.00	1	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

					То	12/31/2018	Date/Time Pre 4/27/2020 11:	
		Full Time Equivalents			Di scha	arges	1,2,7,2020	
	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 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	432	15	1, 018	1. 00
2.00	HMO and other (see instructions)				280	19		2. 00
3.00	HMO I PF Subprovi der					0		3. 00
4.00	HMO I RF Subprovi der					O		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
8. 00	beds) (see instructions) 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		o	432	15	1, 018	14. 00
15. 00	CAH visits						.,	15. 00
16. 00	SUBPROVI DER - 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							21.00
22. 00	HOME HEALTH AGENCY	0.00						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE	0. 00						24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 25
27. 00	Total (sum of lines 14-26)	0. 00						27. 00
28. 00	Observation Bed Days							28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days				0			33. 00
	LTCH site neutral days and discharges				0			33. 00
55.01	TETOIT SEE HEULT OF MAYS AND OF SOME YES	ı İ		- 1	O _I	l		33.01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared:

PART I V - WAGE RELATED COSTS		To 12/31/2018	Date/Time Pre 4/27/2020 11:	
PART IV - WAGE RELATED COSTS 1.00			•	00 4
PART I V - WAGE RELATED COSTS				
Part A - Core List RETIREMENT COST				
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.41,46,988 3.00 0.0	1.00	401K Employer Contributions	0	1. 00
A. 00 Qualified Defined Benefit Plan Cost (see instructions) Q 4.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	233, 716	2. 00
A. 00 Qualified Defined Benefit Plan Cost (see instructions) Q 4.00	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 146, 988	3. 00
5.00 dolk/TSA Plan Administration fees 0 5.00 Legal /Accounting/Management Fees-Pension Plan 2.098 6.00 Employee Managed Care Program Administration Fees 32,880 7.00 Employee Managed Care Program Administration Fees 32,880 7.00 Health Insurance (Purchased or Self Funded) 0 8.00 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Health Insurance (Self Funded without a Third Party Administrator) 0 8.03 9.00 Prescription Drug Plan 0 9.00	4.00		0	4. 00
		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
The color of the	5.00	401K/TSA Plan Administration fees	0	5. 00
HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded) 8.00 Health Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Health Insurance (Self Funded without a Third Party Administrator) 2,567,054 8.02 8.03 Health Insurance (Purchased) 0 8.03 10.00 Health Insurance (Purchased) 0 8.03 10.00 10.00 Dental, Hearing and Vision Plan 0 0,900 10.	6.00	Legal /Accounting/Management Fees-Pension Plan	2, 098	6. 00
Real th Insurance (Purchased or Self Funded) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded without a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Self Funded with a Third Party Administrator) Real th Insurance (Purchased) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (If employee is owner or beneficiary) Real th Insurance (Insurance (Insurance (Insurance (Insurance (Insur	7.00	Employee Managed Care Program Administration Fees	32, 880	7. 00
Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01		HEALTH AND INSURANCE COST		
Heal th Insurance (Self Funded with a Third Party Administrator) 2,567,054 8.02	8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 03 Heal th Insurance (Purchased) 9. 00 9. 00 10. 00	8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 26,187 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 59,342 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 14.00 15.00 Workers' Compensation Insurance 14.308 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 7AXES 0 16.00 16.00 17.00 Medicare Taxes - Employers Portion Only 908,138 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 State or Federal Unemployment Taxes 0 20.00 0.00 State or Federal Unemployment Taxes 0 20.00 0.00 Title In Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 58,372 21.00	8.02	Health Insurance (Self Funded with a Third Party Administrator)	2, 567, 054	8. 02
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 26, 187 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 59, 342 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 14, 308 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 16.00 17.00 FI CA-Employers Portion Only 908, 138 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 OTHER 21.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 58, 372 17.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 34, 651 23.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 20.00 25.00 Contact 20.00 26.00 26.00 27.00 27.00 28.00 29.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.	8.03	Health Insurance (Purchased)	0	8. 03
11.00 Life Insurance (If employee is owner or beneficiary) 26, 187 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 59, 342 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 14, 308 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 7 908, 138 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 58, 372 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 58, 372 22.00 Day Care Cost and Allowances 34, 651 23.00 23.00 Tuit ion Reimbursement 34, 651 23.00 24.00 Part B - Other than Core Related Cost 34, 365 34, 365 34, 365 35, 363 34.00 Part B - Other than Core Related Cost 34, 365 34, 365 36, 365	9.00	Prescription Drug Plan	0	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) Vorkers' Compensation Insurance 14.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 0 Unemployment Insurance 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances 13.00 14.00 14.00 16.00 16.00 17.00 18.00 19.00 19.00 20.00 21.00 22.00 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11.00	Life Insurance (If employee is owner or beneficiary)	26, 187	11. 00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes ODIHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	13.00	Disability Insurance (If employee is owner or beneficiary)	59, 342	13. 00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion TAXES TI CA-Employers Portion Only 908, 138 17.00	15.00	'Workers' Compensation Insurance	14, 308	15. 00
TAXES 17.00 FI CA-Employers Portion Only 908, 138 17.00 18.00 18.00 19	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00				
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 58,372 above. 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 34,651 above. 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 5,083,734 above. 24.00				
19.00 Unemployment Insurance 0 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 34,651 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,083,734 24.00 Part B - Other than Core Related Cost	17. 00		908, 138	17. 00
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 34,651 23.00 Total Wage Related cost (Sum of Lines 1 -23) 5,083,734 24.00 Part B - Other than Core Related Cost			0	
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 33.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 22.00 24.00 24.00			0	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 21.00 22.00 23.00 24.00 25.00 26.00 27.00 29.00 29.00 20.00	20.00		0	20. 00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 1 instructions) 22.00 23.00 24.00 25.00 26.00 27.00 29.00 29.00 20.00		•		
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 34, 651 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 5, 083, 734 24. 00 Part B - Other than Core Related Cost 24. 00	21. 00		58, 372	21. 00
23.00 Tuition Reimbursement 34,651 23.00 24.00 Total Wage Related cost (Sum of lines 1 -23) 5,083,734 24.00 Part B - Other than Core Related Cost				
24.00 Total Wage Related cost (Sum of lines 1 -23) 5,083,734 Part B - Other than Core Related Cost			-	
Part B - Other than Core Related Cost				
	24. 00	,	5, 083, 734	24. 00
25.00 OTHER WAGE RELATED COSTS (SPECIFY) 0 25.00				
	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-1310	Peri od: Worksheet S-3 Part V To 12/31/2018 Date/Time Prepared:

		0 12/31/2018	4/27/2020 11:0	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	5, 083, 734	1.00
2.00	Hospi tal	0	5, 083, 734	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17. 00
18. 00	Other	0	0	18. 00

SPIT	AL UNCOMPENSATED AND INDIGENT CARE DATA Prov	ider CCN: 15		Peri od:	Worksheet S-10	0	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	nare	
				12/31/2010	4/27/2020 11:0		
					1. 00		
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	d by line 20:	2 column	8)	0. 297077	1.	
00	Medicaid (see instructions for each line) Net revenue from Medicaid		492, 539	2			
00	Did you receive DSH or supplemental payments from Medicaid?				492, 539 N	3	
00	If line 3 is yes, does line 2 include all DSH and/or supplemental p	payments from	m Medicai	d?	N	4	
00	If line 4 is no, then enter DSH and/or supplemental payments from N		0	5			
00	Medi cai d charges		7, 449, 371	6			
00	Medicaid cost (line 1 times line 6)	0 15 16	2, 213, 037	7			
00	Difference between net revenue and costs for Medicaid program (line < zero then enter zero)	e / minus su	m of line	es 2 and 5; if	1, 720, 498	8	
	Children's Health Insurance Program (CHIP) (see instructions for ea	ach line)					
00	Net revenue from stand-alone CHIP				0	9	
00	Stand-alone CHIP charges				0	10	
00	Stand-alone CHIP cost (line 1 times line 10)			_	0	11	
00	Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus li	ine 9; i	f < zero then	0	12	
	<pre>enter zero) Other state or local government indigent care program (see instruct</pre>	tions for eac	ch line)				
00	Net revenue from state or local indigent care program (Not included)	1, 064, 383	13	
00	Charges for patients covered under state or local indigent care pro				10, 142, 589		
	10)						
00	State or local indigent care program cost (line 1 times line 14)				3, 013, 130		
00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 1,948,747 16.0						
		nt care prog	ıram (line	e is minus iine	1, 948, 747	16	
	13; if < zero then enter zero)		,			16	
			,			16	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to funding	nd state/loca	al indige		ns (see	17	
. 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi	nd state/loca ng charity ca tal operation	al indige are ons	ent care program	ns (see	17 18	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local independent.	nd state/loca ng charity ca tal operation	al indige are ons	ent care program	ns (see	17 18	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi	nd state/loca ng charity ca ital operation digent care p	al indige are ons	ent care program	ns (see	17 18	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local independent.	nd state/locating charity catal operation digent care	al indigerare ons programs insured atients	(sum of lines	0 0 3,669,245 Total (col. 1 + col. 2)	17 18	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16)	nd state/locating charity catal operation digent care	al indigerare ons programs	ent care program (sum of lines	0 0 3,669,245 Total (col. 1	17 18	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line)	nd state/locating charity contains the care part of the c	al indigeral al in	(sum of lines Insured patients 2.00	0 0 3,669,245 Total (col. 1 + col. 2) 3.00	17 18 19	
00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit	nd state/locating charity contains the care part of the c	al indigerare ons programs insured atients	(sum of lines Insured patients 2.00	0 0 3,669,245 Total (col. 1 + col. 2) 3.00	17 18 19	
00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line)	nd state/local ng charity cal tal operation digent care Uni pa	al indigeral al in	(sum of lines Insured patients 2.00 468,625	0 0 3,669,245 Total (col. 1 + col. 2) 3.00	17 18 19	
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	nd state/local ng charity call tall operation digent care Unit pa	al indigerare ons programs insured on tients 1.00 1,407,84	(sum of lines Insured patients 2.00 468,625	0 0 3,669,245 Total (col. 1 + col. 2) 3.00 1,876,471 886,864	177 188 199 200 211	
00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	nd state/local ng charity call tall operation digent care Unit pa	al indigerare ons programs insured tients 1.00	(sum of lines Insured patients 2.00 468,625	0 0 3,669,245 Total (col. 1 + col. 2) 3.00	177 188 199 200 211	
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00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	nd state/local ng charity call tall operation digent care Unit pa	al indigerare ons programs insured on tients 1.00 1,407,84	(sum of lines Insured patients 2.00 468,625 9 468,625 3 11,496	0 0 3,669,245 Total (col. 1 + col. 2) 3.00 1,876,471 886,864	177 188 199 200 211	
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00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the in	d state/local ng charity can tal operation digent care plus by the care as a says beyond a gram?	al indigerare ons programs insured atients 1.00 1,407,84 418,23 9,79 408,44	(sum of lines Insured patients 2.00 468,625 468,625 3 11,496 457,129 of stay limit	1s (see 0 0 3, 669, 245 Total (col. 1 + col. 2) 3.00 1, 876, 471 886, 864 21, 289 865, 575 1.00	177 188 199 200 211 222 233	
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00 00 00 00 00 00 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dai imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit	d state/local ng charity can tal operation di gent care particular di gent care particular di gent care particular di gent care as ays beyond a gram? Indi gent care ctions)	al indigerare ons programs insured titients 1.00 1,407,844 418,23 9,79 408,44	(sum of lines Insured patients 2.00 468,625 468,625 3 11,496 457,129 of stay limit	1s (see 0 0 3, 669, 245 Total (col. 1 + col. 2) 3. 00 1, 876, 471 886, 864 21, 289 865, 575 1. 00 N	177 188 199 200 211 222 233 244 255 260	
00 00 00 00 00 00 00 00 00 01	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dai imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct on the individual complex (see instruct on the individual complex (see instruct on the ind	d state/local ng charity call tall operation digent care part of the care	al indigerare ons programs insured titients 1.00 1,407,844 418,23 9,79 408,444 Tength ons)	(sum of lines Insured patients 2.00 468,625 468,625 3 11,496 457,129 of stay limit	1s (see 0 0 3, 669, 245 Total (col. 1 + col. 2) 3.00 1, 876, 471 886, 864 21, 289 865, 575 1.00 N 0 3, 875, 383 636, 630 979, 431	177 188 199 200 211 222 233 244 255 266 277 277	
00 00 00 00 00 00 00 00 00 01 00	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see incomplex) Medicare allowable bad debts for the entire hospital complex (see incomplex)	d state/local ng charity can tal operation digent care plants the state of the stat	al indigerare ons programs insured stients 1.00 1,407,84 418,23 9,79 408,44 or length of program' ons)	(sum of lines Insured patients 2.00 468,625 468,625 3 11,496 457,129 of stay limit	1s (see 0 3, 669, 245 Total (col. 1 + col. 2) 3.00 1, 876, 471 886, 864 21, 289 865, 575 1.00 N 0 3, 875, 383 636, 630 979, 431 2, 895, 952	20 21 22 23 24 25 26 27 27 28	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local ind 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dai imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instruct Medicare reimbursable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct Medicare allowable bad debts for the entire hospital complex (see instruct on the individual complex (see instruct on the individual complex (see instruct on the ind	d state/local ng charity can tal operation digent care plants the state of the stat	al indigerare ons programs insured stients 1.00 1,407,84 418,23 9,79 408,44 or length of program' ons)	(sum of lines Insured patients 2.00 468,625 468,625 3 11,496 457,129 of stay limit	1s (see 0 0 3, 669, 245 Total (col. 1 + col. 2) 3.00 1, 876, 471 886, 864 21, 289 865, 575 1.00 N 0 3, 875, 383 636, 630 979, 431	20 21 22 23 24 25 26 27 27 28 29	

	ARKVIEW WABASH H			In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-1310 F	Period: From 01/01/2018	Worksheet A	
				Γο 12/31/2018	Date/Time Pre 4/27/2020 11:	pared: 05 am
Cost Center Description	Sal ari es	Other		Reclassifications (See A-6)	Reclassified Trial Balance	
			+ col . 2)	ons (see A-o)	(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT		6, 279, 801	6, 279, 80	-649, 938	5, 629, 863	1.00
2.00 OO200 CAP REL COSTS-BLDG & FIXT		0, 279, 601	0, 279, 60		1, 227, 824	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	72, 687	4, 412, 932	`		4, 483, 419	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	775, 759	13, 995, 817			14, 698, 271	5. 00
7.00 00700 OPERATION OF PLANT	302, 360	1, 005, 272	1, 307, 632	-1, 336	1, 306, 296	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	0	[[0	0	8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	251, 455 500, 047	261, 103 366, 170			512, 558 173, 185	9. 00 10. 00
11. 00 01100 CAFETERI A	0	300, 170	000, 21		687, 313	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	307, 997	21, 860	329, 85		327, 940	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	O	0	(o	0	14. 00
15. 00 01500 PHARMACY	695, 032	510, 773	1, 205, 805	-277, 937	927, 868	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	(0	0	16. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 720, 639	1, 420, 841	3, 141, 480	-699, 743	2, 441, 737	30.00
43. 00 04300 NURSERY	1, 720, 037	1, 420, 041		142, 495	142, 495	43. 00
ANCILLARY SERVICE COST CENTERS	-1					
50. 00 05000 OPERATING ROOM	642, 679	761, 684	1, 404, 363	-100, 169	1, 304, 194	50. 00
51. 00 05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0	0	1 (555, 482	555, 482	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	829, 579	18 829, 762	•		18 1, 657, 269	53. 00 54. 00
56. 00 05600 RADI 0I SOTOPE	027, 377	027, 702	1,037,34	0	1, 037, 207	56.00
60. 00 06000 LABORATORY	o	1, 558, 639	1, 558, 639	9 0	1, 558, 639	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(o o	0	63. 00
66. 00 06600 PHYSI CAL THERAPY	987, 093	131, 788	1, 118, 881		806, 573	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		132, 236	132, 236	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	467, 593	54, 513	522, 106	94, 337 -4, 159	94, 337 517, 947	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	927, 521			433, 888	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	. (493, 633	493, 633	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 104, 771				73. 00
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	199	199	9 0	199	76. 98
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	O	131, 522	131, 522	5, 719	137, 241	90.00
90. 01 09001 SENI OR CARE	127, 921	101, 708			229, 629	90. 01
91. 00 09100 EMERGENCY	609, 517	2, 698, 407				91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	T al	405.070	105.07		405.070	05.00
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	0	185, 072 0		2 O O O		95. 00 101. 00
SPECIAL PURPOSE COST CENTERS	ı o	0		<u>J</u>	U	1101.00
113. 00 11300 I NTEREST EXPENSE		302, 118	302, 118	-302, 118	0	113. 00
116. 00 11600 HOSPI CE	o	0	(o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 290, 358	39, 062, 291	47, 352, 649	9 0	47, 352, 649	118. 00
NONREI MBURSABLE COST CENTERS	07.074	, 550	44.50		44 500	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	37, 971 125, 554	6, 559 117, 163			44, 530 242, 717	190.00
192. 01 19201 PV WABASH HEALTH CLINC-CASS	123, 334	1, 722, 419		1	1, 722, 419	1
192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH	o	1, 395, 061			1, 395, 061	1
192.03 19203 PV WABASH HEALTH CLINC-KISSINGER	o	1, 219, 099	1, 219, 099	9 0	1, 219, 099	1
194. 00 07950 FITNESS CENTER	0	0	(194. 00
194. 01 07951 FOUNDATION	0	-635, 044	-635, 044	1 0	-635, 044	
194. 02 07952 NEW DIRECTION 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES		49, 802	49, 802			194. 02 194. 03
194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS		47, 502	77,002			194. 04
194. 05 07955 OCCUPATI ONAL HEALTH	0	0				194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	8, 453, 883	42, 937, 350	51, 391, 233	3 o	51, 391, 233	200. 00

Provider CCN: 15-1310

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 4/27/2020 11:05 am

					/27/2020 11:05 am
	Cost Center Description	Adjustments	Net Expenses		
	μ		For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-4, 018, 269	1, 611, 594		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-18, 122	1, 209, 702		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 324, 916	3, 158, 503		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 225, 248		1	5. 00
7. 00	00700 OPERATION OF PLANT	-349, 248		1	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	1	8. 00
9. 00	00900 HOUSEKEEPI NG	0	512, 558		9. 00
10. 00	01000 DI ETARY	-3, 247	169, 938	•	10.00
11. 00	01100 CAFETERI A	0,247	687, 313	·	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	327, 940	•	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	327, 740	1	14. 00
	1 1	200 (0)			l l
15.00	01500 PHARMACY	-298, 686		1	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	<u>/ </u>	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0/0.0/7	0.070.770	ı .	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	-368, 967	2, 072, 770		30.00
43.00	04300 NURSERY	0	142, 495		43. 00
	ANCILLARY SERVICE COST CENTERS	ı			
50. 00	05000 OPERATING ROOM	0		1	50. 00
51. 00	05100 RECOVERY ROOM	0	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	555, 482		52. 00
53.00	05300 ANESTHESI OLOGY	0	18	3	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-143, 243	1, 514, 026		54.00
56.00	05600 RADI OI SOTOPE	0	0		56.00
60.00	06000 LABORATORY	0	1, 558, 639)	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600 PHYSI CAL THERAPY	0	806, 573		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	132, 236	1	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	94, 337	l .	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	517, 947		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	433, 888	•	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	493, 633	l control of the cont	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS		177	1	70. 78
90. 00	09000 CLINIC	0	137, 241		90. 00
		0			
90. 01	09001 SENI OR CARE	((0.42)	229, 629	l .	90. 01
91.00	09100 EMERGENCY	-669, 436	2, 635, 770	1	91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS		_		
	09500 AMBULANCE SERVICES	-185, 072		•	95. 00
101.00	10100 HOME HEALTH AGENCY	0	0		101. 00
	SPECIAL PURPOSE COST CENTERS	1		1	
	11300 INTEREST EXPENSE	0	0		113. 00
	11600 HOSPI CE	0	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-10, 604, 454	36, 748, 195		118. 00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-5, 995	38, 535		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	242, 717	'	192. 00
192. 01	19201 PV WABASH HEALTH CLINC-CASS	0	1, 722, 419)	192. 01
192. 02	19202 PV WABASH HEALTH CLINC-N. MANCH	0	1, 395, 061		192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	1	1	192. 03
	07950 FITNESS CENTER	0	0	1	194. 00
	07951 FOUNDATION	635, 044	١		194. 01
	07952 NEW DIRECTION	000, 044	١		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	49, 802		194. 03
	107956 OTHER NONREIMBURSABLE COST CENTERS	0	49,802	1	194. 04
	07955 OCCUPATIONAL HEALTH	0	1		194. 04
200.00		-9, 975, 405			200. 00
200.00	/ TOTAL (JOW OF LINES THE CHILDUGH 199)	- 7, 775, 405	1 41,410,020	' I	J200. 00

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-1310

					То	12/31/2018	Date/Ti me 4/27/2020	Prepared:
		Increases					472172020	11.03 am
	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	115, 150	17, 086				1. 00
2.00	SPEECH PATHOLOGY	68. 00	82, 148	12, 189				2. 00
	0		197, 298	29, 275				
	B - CLINIC DIETICIAN							
1.00	CLINIC	90.00	5, 719	0				1. 00
	0		5, 719	0				
	C - CAFETERIA RECLASS							
1.00	CAFETERI A	<u>11.</u> 00	394, 839	29 <u>2, 4</u> 74				1. 00
	0		394, 839	292, 474				
	D - DRUGS CHARGED TO PATIENTS							
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	277, 546				1. 00
2.00		0. 00	0	0				2. 00
3.00		0.00	0	0				3. 00
4.00		0.00	•	0				4. 00
	0		0	277, 546				
	E - SALARY RECLASS							
1. 00	ADMINISTRATIVE & GENERAL		<u>3, 244, 6</u> 07	0				1. 00
	0		3, 244, 607	0				
	G - DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP		•	<u>1, 076, 567</u>				1. 00
	0			1, 076, 567				
	H - EQUIP & BLDG LEASE			-				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78, 650				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	130, 389				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	0	0				7. 00
8.00		0.00	0	0				8. 00
9.00		0.00	0	0				9. 00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12. 00		0.00		0				12. 00
	U LIMBLANTARI E MERLICAL CUR		0	209, 039				
1 00	I - IMPLANTABLE MEDICAL SUP. IMPL. DEV. CHARGED TO	72.00	O	493, 633				1 00
1. 00	PATIENTS	72.00	ď	493, 633				1. 00
	PATIENTS — — — —	+		493, 633				
	K - INTEREST EXPENSE		U	493, 033				
1. 00		1.00	ol	302, 118				1.00
1.00	CAP REL COSTS-BLDG & FIXT			302, 118				1.00
	L - I NSURANCE		<u> </u>	302, 110				
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	O	45, 861				1. 00
2. 00	CAP REL COSTS-BEDG & TTXT	2. 00	0	20, 868				2. 00
2.00	O NEL COSTS-WYDLL LQUIP			2 <u>0, 808</u> 66, 729				2.00
	M - OB RECLASS		UU	00, 727				
1.00	NURSERY	43.00	31, 982	110, 513				1, 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	124, 675	430, 807				2.00
2.00	TOTALS		124, 675 156, 657	43 <u>0, 807</u> 541, 320				2.00
500 00	Grand Total: Increases		3, 999, 120	3, 288, 701				500. 00
300.00	pirana rotar. Thereases		3, 777, 120	3, 200, 701				500.00

Provider CCN: 15-1310 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					') 11:05 am
		Decreases		·		
	Cost Center	Li ne #	Sal ary	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	197, 298	29, 275	1	1. 00
2.00		0.00	0		<u> </u>	2. 00
	0		197, 298	29, 275		
1 00	B - CLINIC DIETICIAN	10.00	F 710			1 00
1. 00	DI ETARY	1000	<u>5, 719</u>	C	<u> </u>	1. 00
	C - CAFETERIA RECLASS		5, 719)	
1. 00	DI ETARY	10.00	394, 839	292, 474	I 0	1.00
1.00	0		394, 839	2 <u>92, 4</u> 74		1.00
	D - DRUGS CHARGED TO PATIENTS		374, 037	272, 474	•	
1.00	PHARMACY	15. 00	0	276, 020	0	1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	701	1	2. 00
3.00	OPERATING ROOM	50.00	o	712		3. 00
4. 00	EMERGENCY	91. 00	o	113		4. 00
				277, 546		
	E - SALARY RECLASS	<u>'</u>		,	1	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 244, 607	0	1. 00
				3, 244, 607	,	
	G - DEPRECIATION	·				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 076, 567	9	1. 00
	0		0	1, 076, 567	7	
	H - EQUIP & BLDG LEASE					
1.00	PHYSI CAL THERAPY	66. 00	0	78, 650		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 371	1	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 200		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 576		4. 00
5.00	OPERATION OF PLANT	7. 00	0	1, 336		5. 00
6.00	NURSI NG ADMI NI STRATI ON	13. 00	0	1, 917	1	6. 00
7.00	PHARMACY	15. 00	0	1, 917		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	1, 766		8. 00
9.00	OPERATING ROOM	50.00	0	99, 457		9. 00
10.00	ELECTROCARDI OLOGY	69.00	0	4, 159		10.00
11.00	PHYSI CAL THERAPY	66. 00 91. 00	O O	7, 085		11.00
12. 00	EMERGENCY	91.00	0	<u>2, 6</u> 05 209, 039		12. 00
	I - IMPLANTABLE MEDICAL SUP.		О	209, 039	<u>'</u>	
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	493, 633	B O	1.00
1.00	PATI ENT	71.00	٩	170,000	ή	1.00
	0	+		493, 633		·
	K - INTEREST EXPENSE			,		
1.00	I NTEREST EXPENSE	113.00	0	302, 118	11	1. 00
				302, 118		
	L - I NSURANCE	'			1	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	66, 729	12	1. 00
2.00		0.00	o	C	12	2. 00
	0			66, 729		
	M - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	156, 657	541, 320	0	1. 00
2.00		0.00_	0	0	<u> </u>	2. 00
	TOTALS		156, 657	541, 320		
500.00	Grand Total: Decreases		754, 513	6, 533, 308	3	500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1310 Peri od: Worksheet A-7 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 4/27/2020 11:05 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 295, 014 223, 467 223, 467 0 1.00 717, 763 0 717, 763 2.00 Land Improvements 314, 699 0 2.00 0 3.00 12, 586, 529 31, 615, 598 31, 615, 598 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 4, 150, 859 0 4.00 5.00 Fixed Equipment 921, 093 1, 841, 777 1, 841, 777 0 5.00 0 6.00 Movable Equipment 14, 498, 443 8, 760, 627 8, 760, 627 0 6.00 0 7.00 HIT designated Assets 2, 301, 368 7.00 45, 148 45, 148 0 8.00 Subtotal (sum of lines 1-7) 36, 068, 005 43, 204, 380 43, 204, 380 0 8.00 9.00 Reconciling Items 309, 317 243, 404 0 243, 404 0 9.00 42, 960, 976 Total (line 8 minus line 9) 35, 758, 688 42, 960, 976 10.00 10.00 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 518, 481 1.00 Land Improvements 294, 327 2.00 2.00 1, 032, 462 . Buildings and Fixtures 44, 202, 127 12, 527, 725 3.00 3.00 2, 849, 352 4.00 Building Improvements 4, 150, 859 4.00 5.00 Fi xed Equipment 2, 762, 870 699, 975 5.00 23, 259, 070 12, 177, 132 6.00 Movable Equipment 6.00 7.00 HIT designated Assets 1, 821, 935 7.00 2, 346, 516

79, 272, 385

78, 719, 664

552, 721

30, 370, 446

30, 370, 446

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-1310	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	nared·
					12,01,2010	4/27/2020 11:	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	Social Secondary Princing	5 op: 00: at: 0::	20000	111101001	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 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 279, 801	0		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	6, 279, 801	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		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	· ·				
1.00	CAP REL COSTS-BLDG & FLXT	0	6, 279, 801				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	6, 279, 801				3. 00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	Period: From 01/01/2018 To 12/31/2018		pared:
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1	F0 /// 00/	0 (07(40		4 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	53, 666, 800		,,			1. 00 2. 00
3.00 Total (sum of lines 1-2)	23, 259, 070 76, 925, 870		23, 259, 070 76, 925, 870			3. 00
3. 00 Total (Suill Of Titles 1-2)	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				3.00	
					OALLIAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
· ·		Capi tal -Relate	col s. 5	'		
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0	(1, 184, 965		1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(1, 058, 445		2. 00
3.00 Total (sum of lines 1-2)	0	0	(2, 243, 410	209, 039	3. 00
		St	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00 CAP REL COSTS-BLDG & FLXT	302, 118				1, 611, 594	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	20,000		1	1, 209, 702	2.00
3.00 Total (sum of lines 1-2)	302, 118	66, 729	(0	2, 821, 296	3. 00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-1310

				To	12/31/2018	Date/Time Prep 4/27/2020 11:0	
				Expense Classification on To/From Which the Amount is		4/2//2020 11.0	os alli
				TOTTOM WITCH THE AMOUNT 13	to be haj astea		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	О	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		U		0.00	U	7.00
8.00	21) Tel evi si on and radio service (chapter 21)		0	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -675, 589		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.	7.02	0,0,007		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-1, 798, 567		0.00	0	
13. 00	transactions (chapter 10) Laundry and linen service		., ,		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests		0	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16. 00
17. 00	Sale of drugs to other than patients	В	-298, 686	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
19. 01	books, etc.) Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 01
19. 02	books, etc.) Nursing and allied health		0		0. 00	0	19. 02
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-211, 649 0	OPERATION OF PLANT	7. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)				5. 55		
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)		_		33.33		
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-4, 018, 269	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00	_	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

				To	12/31/2018	Date/Time Pre 4/27/2020 11:	
				Expense Classification on	Worksheet A	172772020 1111	00 4
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	•	1.00	2.00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	DEPRECIATION HIT ASSETS	Α	-7, 956	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	2016						
33. 01	DEPRECIATION HIT ASSETS	A	-139, 872	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
	PRI OR						
34.00	RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	34.00
38. 00	SELF INSURANCE ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	38. 00
39. 00	LOBBYI NG	A	-4, 288	ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	MARKETI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
40. 01	TELEVISION SERVICE	A	•	OPERATION OF PLANT	7. 00	0	40. 01
42.00	LI QUOR ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	42.00
42. 01	LI QUOR ADJUSTMENT	A		DI ETARY	10. 00	0	42. 01
42. 02	TELEVI SI ON	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	42. 02
44.00	EMS ADJUSTMENT	A		AMBULANCE SERVICES	95. 00	0	44. 00
45.00	TELEMETRY MONITORING	A	•	ADULTS & PEDIATRICS	30.00	0	45. 00
45. 01	FI TNESS CENTER	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 01
45. 02	PURCHASING DI SCOUNTS	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
46. 01	HHH ADJUSTMENT	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	46. 01
48. 00	OTHER OPERATING REV	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	48. 00
49. 00	OTHER OPERATING REV	A		DI ETARY	10. 00	0	49. 00
49. 01	OTHER OPERATING REV	A	•	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	49. 01
				CANTEEN			
49. 02	HEARTSMART SCAN READS	A	•	RADI OLOGY-DI AGNOSTI C	54. 00	0	
49. 03	HAF FEE EXPENSE ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 03
49. 04	HOSPITALIST AVAILABILITY COVERAGE	A	-394, 000	ADULTS & PEDIATRICS	30. 00	0	49. 04
49. 05	PHYSICIAN CLINIC RENT OFFSET	В	-131 644	OPERATION OF PLANT	7. 00	0	49. 05
49. 06	REMOVE FOUNDATION REVENUE	A		FOUNDATION	194. 01	n	49. 06
50. 00	TOTAL (sum of lines 1 thru 49)	1	-9, 975, 405		177.01		50.00
50.00	(Transfer to Worksheet A,		7, 775, 405				30.00
	column 6, line 200.)						
(4)				CMC Duk 1E 1			

⁽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.

					4/27/2020 11:	<u>05 am</u>		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount			
			·	Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2. 00	3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:							
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	9, 186, 502	5, 817, 000	1. 00		
2.00	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY (PPG)	0	4, 578, 133	2. 00		
3.00	5. 00	ADMINISTRATIVE & GENERAL	HO INTEREST EXPENSE ELIMINAT	0	589, 936	3. 00		
4.00	0.00			0	0	4. 00		
5.00	TOTALS (sum of lines 1-4).			9, 186, 502	10, 985, 069	5. 00		
	Transfer column 6, line 5 to							
	Worksheet A-8, column 2,							
	line 12.							

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

·			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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	0. 00 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.

Heal th	Financial Syste	ems	PARKVIEW WABASH F	IOSPI TAL, INC.	In Lie	u of Form CMS	S-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1310	Peri od:	Worksheet A	-8-1
OFFICE	COSTS				From 01/01/2018 To 12/31/2018	Date/Time P 4/27/2020 1	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:					
1.00	3, 369, 502	0					1.00
2.00	-4, 578, 133	0					2.00
3.00	-589, 936	0					3.00
4.00	0	0					4.00
5.00	-1, 798, 567						5. 00
* The	amounts on line	es 1-4 (and sub	oscripts as appropriate) are tra	ansferred in detail to Wor	ksheet A, column	6, lines as	
			se cost and negative amounts de				t which
			columns 1 and/or 2, the amount		•		
	Related Orga	ani zati on(s)				•	

Related Organization(s)
and/or Home Office

Type of Business
6.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	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:
- 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 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1310

									То	12/31/2018	Date/Time Pre 4/27/2020 11:	
	Wkst. A Line #		Cost	Center/Physician	Total	Pro	ofessi onal	Provi der		RCE Amount	Physi ci an/Prov	oo aiii
				I denti fi er	Remuneration	1	omponent	Component			ider Component	
											Hours	
	1. 00			2. 00	3.00		4. 00	5. 00		6. 00	7. 00	
1.00	91. 00				13, 333		0	1		0	0	1. 00
2.00	91. 00				1, 777, 931		669, 436			0	0	2.00
3.00	90. 01				31, 219		0	31, 21	9	0	0	3.00
4.00	90. 01				5, 500		0	5, 50	0	0	0	4. 00
5.00	95. 00		E		6, 153		6, 153		0	0	0	5.00
6.00	0.00				0		0		0	0	0	6. 00
7. 00	0.00				0		0		0	0	0	7. 00
8. 00	0. 00				0		0		0	0	0	8. 00
9.00	0.00				0		0		0	0	0	9. 00
10.00	0.00				0		0		0	0	0	10.00
200.00					1, 834, 136		675, 589		7		0	200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE		Percent of	Cost of			Physician Cost	
				I denti fi er	Limit	Unac		Memberships 8			of Mal practice	
							Limit	Conti nui ng	S	Share of col.	Insurance	
	4.00							Educati on	_	12	44.00	
4 00	1.00	D D	•	2. 00	8.00		9. 00	12. 00		13. 00	14. 00	1 00
1.00	91.00						0		0	0	0	1.00
2.00	91. 00						0		0	0	0	2.00
3.00	90. 01						0		0	0	0	3. 00
4.00	90. 01						0		0	0	0	4. 00
5.00	95. 00		E				0		0	0	0	5. 00
6.00	0.00						0			0	0	6. 00
7.00	0.00						0		0	ŭ	0	7. 00
8.00	0.00						0			0	0	8. 00
9.00	0. 00 0. 00						0		0	0	0	9.00
10.00	0.00						0			0	0	10.00
200.00	Wkst. A Line #		Coot	Center/Physi ci an	Provi der	۸ ما:	usted RCE	RCE	<u> </u>	Adjustment	U	200. 00
	WKSt. A Line #		COST	I denti fi er	Component	Auj	Limit	Di sal I owance		Adjustillent		
				rdentrirei	Share of col.		LIIIII L	DI Sai i Owalice				
					14							
	1.00			2. 00	15. 00		16. 00	17. 00	+	18. 00		
1.00	91. 00	DR.	Α		0		0		o	0		1. 00
2.00	91.00						0		ol	669, 436		2. 00
3.00	90, 01						0		ol	0		3. 00
4.00	90. 01	DR.	D				0		ol	0		4. 00
5.00	95. 00						0		ol	6, 153		5. 00
6.00	0.00						0		0	0		6. 00
7. 00	0. 00					1	0		0	o		7. 00
8.00	0.00					1	0		0	o		8. 00
9.00	0.00					1	0		0	o		9. 00
10.00	0.00					1	0		0	0		10.00
200.00							0		0	675, 589		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 4/27/2020 11:05 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 611, 594 1, 611, 594 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 209, 702 1, 209, 702 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 158, 503 34,602 25, 973 3, 219, 078 4.00 00500 ADMINISTRATIVE & GENERAL 509, 100 13, 477, 464 5 00 11, 473, 023 382 142 1, 113, 199 5 00 7.00 00700 OPERATION OF PLANT 957, 048 104, 719 78, 605 83, 721 1, 224, 093 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 512, 558 36, 878 27, 681 69, 626 646, 743 9.00 9.00 01000 DI ETARY 10.00 169, 938 27, 548 305, 272 10 00 61, 570 46, 216 11.00 01100 CAFETERI A 687, 313 44, 368 33, 304 109, 327 874, 312 11.00 01300 NURSING ADMINISTRATION 327, 940 20, 195 13.00 15, 159 85, 282 448, 576 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 0 01500 PHARMACY 192, 448 15.00 629, 182 82, 195 61, 698 965, 523 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 2, 809, 262 30.00 03000 ADULTS & PEDIATRICS 2, 072, 770 130, 107 433, 053 30.00 173, 332 43.00 04300 NURSERY 142, 495 932 699 8, 856 152, 982 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 304, 194 159, 212 119, 508 177, 952 1, 760, 866 50.00 05100 RECOVERY ROOM 51.00 51.00 C 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 555, 482 7,616 5, 716 34, 521 603, 335 52.00 05300 ANESTHESI OLOGY 53.00 18 1, 541 1, 157 2,716 53.00 1, 954, 753 54.00 05400 RADI OLOGY-DI AGNOSTI C 120, 542 90, 482 229, 703 54.00 1, 514, 026 56.00 05600 RADI OI SOTOPE 56, 00 0 60.00 06000 LABORATORY 1, 558, 639 58, 291 43, 755 0 1, 660, 685 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 66.00 06600 PHYSI CAL THERAPY 806, 573 8.476 6.362 218, 687 1, 040, 098 66.00 06700 OCCUPATIONAL THERAPY 67.00 132, 236 C 31, 884 164, 120 67.00 22, 746 06800 SPEECH PATHOLOGY 94, 337 117,083 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 517, 947 58, 685 44, 051 129, 472 750, 155 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 433.888 71 00 433, 888 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 493, 633 0 0 493, 633 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 3, 382, 317 0 0 3, 382, 317 73.00 07698 HYPERBARI C OXYGEN THERAPY 76.98 199 199 76.98 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 137, 241 1,021 767 1,584 140, 613 90.00 90. 01 09001 SENIOR CARE 229, 629 22, 327 16, 759 35, 420 304, 135 90.01 09100 EMERGENCY 56, 829 2.937.077 91.00 91 00 2 635 770 75 708 168 770 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 0 116.00 116. 00 11600 HOSPI CE 1, 581<u>, 310</u> 36, 649, 900 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 36, 748, 195 1, 186, 970 3, 173, 799 118.00 NONREIMBURSABLE COST CENTERS 67, 840 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 38, 535 10, 734 8, 057 10, 514 192.00 19200 PHYSICIANS' PRIVATE OFFICES 277, 482 192. 00 242.717 34.765 C 0 192. 01 19201 PV WABASH HEALTH CLINC-CASS 1, 722, 419 192. 01 1, 722, 419 Ω 0 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 1, 395, 061 0 0 1, 395, 061 192. 02 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 1, 219, 099 Ω 0 1, 219, 099 192. 03 194. 00 07950 FITNESS CENTER 0 194 00 0 0 194. 01 07951 FOUNDATI ON 7, 221 5, 421 12, 642 194. 01 194.02 07952 NEW DIRECTION 0 0 194. 02 C 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 51, 465 194. 03 49.802 950 713 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 01194.04 C 0 194. 05 07955 OCCUPATIONAL HEALTH 0 11, 379 19, 920 194. 05 8, 541 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 1, 611, 594 1, 209, 702 3, 219, 078 202.00 TOTAL (sum lines 118 through 201) 41, 415, 828 41, 415, 828 202. 00

Health Financial Systems

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

Peri od: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 4/27/2020 11:05 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	US AIII
		5. 00	7. 00	8.00	9. 00	10.00	
GENEF	RAL SERVICE COST CENTERS	_					
	CAP REL COSTS-BLDG & FLXT						1. 00
	CAP REL COSTS-MVBLE EQUIP						2. 00
	EMPLOYEE BENEFITS DEPARTMENT						4. 00
	DADMINISTRATIVE & GENERAL	13, 477, 464					5. 00
7.00 00700	OPERATION OF PLANT	590, 502	1, 814, 595				7. 00
	D LAUNDRY & LINEN SERVICE	0	0	0			8. 00
	HOUSEKEEPI NG	311, 989		0	1, 021, 340		9. 00
	D DI ETARY	147, 263	104, 529	0	60, 936	618, 000	10. 00
	CAFETERI A	421, 768		0	43, 911	0	11. 00
	NURSING ADMINISTRATION	216, 393	34, 285	0	19, 987	0	13. 00
	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
	PHARMACY	465, 768	139, 544	0	81, 349	0	15. 00
	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	FLENT ROUTINE SERVICE COST CENTERS						
	DADULTS & PEDIATRICS	1, 355, 188	294, 271		· ·	618, 000	30. 00
	NURSERY	73, 799	1, 582	0	922	0	43. 00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	849, 442		0	157, 573	0	00.00
	RECOVERY ROOM	0	0	· ·	0	0	51. 00
	DELIVERY ROOM & LABOR ROOM	291, 049	1	1	7, 537	0	52. 00
	ANESTHESI OLOGY	1, 310	1	1	1, 525	0	53. 00
	RADI OLOGY-DI AGNOSTI C	942, 973	204, 647	0	119, 301	0	54. 00
	RADI OI SOTOPE	0	0	0	0	0	56. 00
	LABORATORY	801, 114	95, 828	0	55, 864	0	60. 00
	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
	PHYSI CAL THERAPY	501, 743	196, 920	0	114, 797	0	66. 00
	OCCUPATIONAL THERAPY	79, 171	0	0	0	0	67. 00
	SPEECH PATHOLOGY	56, 481		0	0	0	68. 00
	D ELECTROCARDI OLOGY	361, 875		0	58, 081	0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	209, 308		0	0	0	71. 00
	DIMPL. DEV. CHARGED TO PATIENTS	238, 129		0	0	0	72. 00
	D DRUGS CHARGED TO PATIENTS	1, 631, 627		0	0	0	
	B HYPERBARI C OXYGEN THERAPY	96	0	0	0	0	76. 98
	ATIENT SERVICE COST CENTERS	(7.022	1 704	1 0	1 011	0	00.00
	CLINIC	67, 832		1	, -	0	
	1 SENI OR CARE	146, 715	1	1	,,	0	90. 01
	D EMERGENCY	1, 416, 846	128, 532	0	74, 929	0	
	O OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	R REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	0	0	0	0	95. 00
	HOME HEALTH AGENCY			1		_	101. 00
	AL PURPOSE COST CENTERS			<u> </u>	U	U	1101.00
	INTEREST EXPENSE						113. 00
116. 00 11600		0	0	О	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	11, 178, 381	1, 763, 182	1		618, 000	
	EI MBURSABLE COST CENTERS	11, 170, 001	1,700,102	·I	771,000	010,000	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32, 726	18, 223	0	10, 623	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	133, 857		1	0		192. 00
192 01 1920	1 PV WABASH HEALTH CLINC-CASS	830, 895		0	0		192. 01
	2 PV WABASH HEALTH CLINC-N. MANCH	672, 977		0	0		192. 02
	PV WABASH HEALTH CLINC-KISSINGER	588, 093		0	0		192. 03
	FITNESS CENTER	0	1 0	o o	o o		194. 00
	1 FOUNDATION	6, 099	12, 260	Ó	7, 147		194. 01
	2 NEW DIRECTION	0	0	Ō	O		194. 02
	COMMUNITY & VOLUNTEER SERVICES	24, 827	1, 612	0	940		194. 03
	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	OCCUPATIONAL HEALTH	9, 609	19, 318	0	11, 262		194. 05
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	13, 477, 464	1, 814, 595	0	1, 021, 340	618, 000	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

				To	12/31/2018	Date/Time Pre 4/27/2020 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	OS dill
	'		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
	CENEDAL CEDALCE COCT CENTEDO	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	1, 415, 315					11. 00
13.00	01300 NURSING ADMINISTRATION	53, 652	772, 893				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0			14. 00
15. 00	01500 PHARMACY	122, 223	0	0	1, 774, 407		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	000 040	000 5/7		47.047		1 00 00
30.00	03000 ADULTS & PEDI ATRI CS	393, 062		0	46, 316 9	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	11, 016	U	9	U	43. 00
50. 00	05000 OPERATING ROOM	141, 445	161, 047	0	2, 237	0	50.00
51. 00	05100 RECOVERY ROOM	141, 443	101, 047	0	2, 23,	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		42, 935	0	28	0	
53. 00	05300 ANESTHESI OLOGY	0	0	0	1, 983	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	215, 324	0	0	13, 797	0	1
56.00	05600 RADI OI SOTOPE	0	o	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	179, 748		0	23, 130	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	13, 485	0	0	2, 293	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	13, 054	0	0	602	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	107, 160	0	0	0	0	69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	0	1, 665, 948	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY		_	0	1, 003, 940	0	1
70. 70	OUTPATIENT SERVICE COST CENTERS		<u> </u>	0	<u> </u>		70. 70
90.00	09000 CLINIC	1, 291	l ol	0	0	0	90.00
90. 01	09001 SENI OR CARE	30, 556		O	0	0	90. 01
91.00	09100 EMERGENCY	144, 315	164, 328	0	18, 064	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0		0	0	0	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS	I	1				112 00
	11300 INTEREST EXPENSE 11600 HOSPICE	0	0	0	0	0	113. 00 116. 00
118.00		1, 415, 315		0	1, 774, 407		118.00
110.00	NONREI MBURSABLE COST CENTERS	1,415,515	112,073	O _I	1, 774, 407	0	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES			0	0		192. 00
	19201 PV WABASH HEALTH CLINC-CASS	0	-	0	0		192. 01
192. 02	19202 PV WABASH HEALTH CLINC-N. MANCH	0	О	0	0		192. 02
192. 03	19203 PV WABASH HEALTH CLINC-KISSINGER	0	o	0	0	0	192. 03
194.00	07950 FI TNESS CENTER	0	0	0	0	0	194. 00
	07951 FOUNDATI ON	0	0	0	0		194. 01
	07952 NEW DIRECTION	0	0	0	0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	이	0	0		194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 04
	07955 OCCUPATIONAL HEALTH			0	O	0	194. 05
200. 00 201. 00		_			0	^	200. 00 201. 00
201.00		1, 415, 315	772, 893	0	1, 774, 407		202. 00
202.00	1.07/12 (Sam 11/105 110 till bugit 201)	1, 415, 515	1 112,093	O _I	1, 777, 707	0	1-02.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310

				Fi To	o 12/31/2018 Da	art I ate/Time Prepared:
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	4/	/27/2020 11: 05 am
		24. 00	25. 00	26.00		
	GENERAL SERVICE COST CENTERS	T T		ı		
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS					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 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	6, 081, 214 240, 310	0	6, 081, 214 240, 310		30. 00 43. 00
50. 00 51. 00 52. 00 53. 00 54. 00 56. 00 60. 00 63. 00 66. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06600 PHYSI CAL THERAPY	3, 342, 907 0 957, 813 10, 150 3, 450, 795 0 2, 613, 491 0 2, 056, 436	0 0 0 0 0 0	3, 342, 907 0 957, 813 10, 150 3, 450, 795 0 2, 613, 491 0 2, 056, 436		50. 00 51. 00 52. 00 53. 00 54. 00 56. 00 60. 00 63. 00 66. 00
67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 98	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	259, 069 187, 220 1, 376, 902 643, 196 731, 762 6, 679, 892 295	0 0 0 0 0	259, 069 187, 220 1, 376, 902 643, 196 731, 762 6, 679, 892 295		67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 98
90. 00 90. 01 91. 00 92. 00	09000 CLI NI C 09001 SENI OR CARE 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	212, 481 541, 408 4, 884, 091	0 0 0 0	212, 481 541, 408 4, 884, 091		90. 00 90. 01 91. 00 92. 00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0	0		95. 00 101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 34, 269, 432	0	0 34, 269, 432		113. 00 116. 00 118. 00
192. 00 192. 01 192. 03 194. 00 194. 01 194. 02 194. 03 194. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER 07950 FITNESS CENTER 07951 FOUNDATION 07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES 07956 OTHER NONREIMBURSABLE COST CENTERS 07955 OCCUPATIONAL HEALTH Cross Foot Adjustments Negative Cost Centers	129, 412 411, 339 2, 553, 314 2, 068, 038 1, 807, 192 0 38, 148 0 78, 844 0 60, 109 0 41, 415, 828	0 0 0 0 0 0 0 0	129, 412 411, 339 2, 553, 314 2, 068, 038 1, 807, 192 0 38, 148 0 78, 844 0 60, 109 0 41, 415, 828		190. 00 192. 00 192. 01 192. 02 192. 03 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 200. 00 201. 00 202. 00

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

				То	12/31/2018	Date/Time Pre 4/27/2020 11:	pared:
			CAPITAL REI	LATED COSTS		472772020 11.	US alli
		5	BI BO & ELVE	10/01 5 50/// 5		5451 0V55	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1.00		0.4		
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4. 00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	34, 602		60, 575		4. 00
5.00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	935, 779	l		1, 827, 021	20, 951	5. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	0	104, 719		183, 324 0	1, 575 0	1
9. 00	00900 HOUSEKEEPI NG	0	36, 878		64, 559		1
10. 00	01000 DI ETARY	0	61, 570		107, 786		1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	44, 368		77, 672		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	20, 195		35, 354 0	1, 605 0	14. 00
15. 00	01500 PHARMACY	0	82, 195	-	143, 893		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	T 0	172 222	120 107	202 420	8. 148	20.00
	04300 NURSERY	0			303, 439 1, 631	167	
10.00	ANCILLARY SERVICE COST CENTERS		, , , ,	57.7	., 55.1		10.00
	05000 OPERATING ROOM	0	159, 212		278, 720	·	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	7 (1)	-	12 222	0	51. 00 52. 00
52.00	05300 ANESTHESI OLOGY	0	7, 616 1, 541		13, 332 2, 698	650 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	120, 542		211, 024		
56. 00	05600 RADI 0I S0T0PE	0	0	-	0	0	
60.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	58, 291	43, 755	102, 046	0	
63. 00 66. 00	06600 PHYSI CAL THERAPY	0	8, 476	6, 362	14, 838		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	600	1
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	428	1
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	58, 685	44, 051 0	102, 736	2, 436 0	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	1, 021	767	1, 788	30	90. 00
	09001 SENI OR CARE	0	22, 327		39, 086		1
	09100 EMERGENCY	0	75, 708		132, 537	3, 176	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0			0		101. 00
	SPECIAL PURPOSE COST CENTERS		-				
	11300 INTEREST EXPENSE						113.00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	935, 779	0 1, 581, 310		0 3, 704, 059		116. 00 118. 00
116.00	NONREIMBURSABLE COST CENTERS	935, 119	1, 301, 310	1, 160, 970	3, 704, 039	59, 725	1116.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 734	8, 057	18, 791	198	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0		192. 01 192. 02
	19203 PV WABASH HEALTH CLINC-N. MANCH	0		0	0		192. 02
	07950 FITNESS CENTER	0	Ö	o o	ő		194. 00
	07951 FOUNDATI ON	0	7, 221	5, 421	12, 642		194. 01
	07952 NEW DIRECTION	0	0 950	0	1 443		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES 07956 OTHER NONREIMBURSABLE COST CENTERS		950	713	1, 663 0		194. 03 194. 04
	07955 OCCUPATI ONAL HEALTH	0	11, 379	8, 541	19, 920		194. 05
200.00	1				o		200. 00
201.00		025 770	1 (11 504	1	0 757 075		201. 00
202. 00	TOTAL (sum lines 118 through 201)	935, 779	1, 611, 594	1, 209, 702	3, 757, 075	00,5/5	202. 00

Heal th Financial Systems

PARKVIEW WABASH HOSPITAL, INC.

In Lieu of Form CMS-2552-10

Provider CCN: 15-1310

Period:
From 01/01/2018
To 12/31/2018

Cost Center Description

ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPING DIETARY

Sequence of Form CMS-2552-10

Worksheet B
Part II
DESCRIPTION OF LAUNDRY & HOUSEKEEPING DIETARY

LINEN SERVICE

GENERAL SERVICE COST CENTERS

1.00
00100 CAP REL COSTS-BLDG & FIXT
2.00
00200 CAP REL COSTS-MVBLE EQUIP

Provider CCN: 15-1310
Period:
From 01/01/2018
Davis Housekeeping
DIETARY

1.00
2.00
00200 CAP REL COSTS-BLDG & FIXT
2.00

	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	9.00	10.00	
	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL	1, 847, 972					5. 00
	00700 OPERATION OF PLANT	80, 968	l				7. 00
	00800 LAUNDRY & LINEN SERVICE	00, 700	203, 007				8. 00
	00900 HOUSEKEEPING	42, 779	1	_	117, 821		9. 00
	01000 DI ETARY	20, 192	l		7, 030	150, 841	10. 00
	01100 CAFETERI A	57, 831	11, 036		5, 066	0	11. 00
	01300 NURSING ADMINISTRATION	29, 671	5, 023		2, 306	0	13. 00
	01400 CENTRAL SERVI CES & SUPPLY	2,70,1	0,020		2,000	0	14. 00
	01500 PHARMACY	63, 865			9, 384	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	00,000	0		0,001	0	16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				٥,		10100
30.00	03000 ADULTS & PEDIATRICS	185, 819	43, 117	0	19, 792	150, 841	30. 00
	04300 NURSERY	10, 119			·	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	116, 472	39, 603	0	18, 177	0	50. 00
	05100 RECOVERY ROOM	0	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	39, 908	1, 894	0	869	0	52.00
53.00	05300 ANESTHESI OLOGY	180	383	0	176	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	129, 297	29, 984	0	13, 762	0	54.00
	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
60.00	06000 LABORATORY	109, 846	14, 040	0	6, 444	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600 PHYSI CAL THERAPY	68, 797	28, 852	0	13, 243	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	10, 856	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	7,744	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	49, 619	14, 598	0	6, 700	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 700	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	32, 651	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	223, 713	0	0	0	0	73.00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13	0	0	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	9, 301	254	0	117	0	90.00
	09001 SENI OR CARE	20, 117	5, 554	0	2, 549	0	90. 01
	09100 EMERGENCY	194, 273	18, 832	0	8, 644	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVICES	0					95. 00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	ı	ı	ı			
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0		0		116. 00
118. 00	. 3 /	1, 532, 731	258, 335	0	114, 365	150, 841	118.00
	NONREI MBURSABLE COST CENTERS	4 407	2 (70	1 0	1 225	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	4, 487					190.00
		18, 354	0	0	0		192. 00
	19201 PV WABASH HEALTH CLINC-CASS	113, 929		0	0		192. 01 192. 02
	19202 PV WABASH HEALTH CLINC-N. MANCH 19203 PV WABASH HEALTH CLINC-KISSINGER	92, 276 80, 637		•	0		192. 02
	07950 FITNESS CENTER	00,037			0		194. 00
	07950 FTTNESS CENTER 07951 FOUNDATION	836			824		194. 00
	07952 NEW DIRECTION	030	1,790		024		194. 01
	07953 COMMUNITY & VOLUNTEER SERVICES	3, 404	236		108	0	194. 02
	07956 OTHER NONREIMBURSABLE COST CENTERS	3, 404	230		0		194. 03
	07955 OCCUPATIONAL HEALTH	1, 318	2, 830	0	1, 299		194. 05
200.00		1,310	2,000		1, 277	O	200. 00
201.00		0	n	О	n	Ω	201. 00
202.00		1, 847, 972	265, 867		117, 821	150, 841	
50	1			'			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

OF CAPITAL RELATED COSTS Provider CCN: 15-1310

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | 12/51/2020 | 14/57 | From 01/01/2020 | 14/57 | Part | I | Prepared: | 14/57 | Part | 14/57 |

			То	12/31/2018	Date/Time Pre 4/27/2020 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	OS alli
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS		1				1 4 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	153, 662					11. 00
13.00 01300 NURSING ADMINISTRATION	5, 825	79, 784				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0			14. 00
15. 00 01500 PHARMACY	13, 270	0	0	254, 478		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	40 (77	40 (07				00.00
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	42, 677 0	40, 627 1, 137	0	6, 642	0	30. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	U	1, 13/	U	I]	0	43.00
50. 00 05000 OPERATING ROOM	15, 357	16, 625	0	321	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 432	0	4	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	284	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	23, 378	o	0	1, 979	0	54.00
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	19, 515	0	0	3, 317	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 464	0	0	329	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 417	0	0	86	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	11, 634 0	0	0	O O	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	238, 924	0	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS		-1		-,		
90. 00 09000 CLI NI C	140	0	0	0	0	90. 00
90. 01 09001 SENI OR CARE	3, 317	0	0	0	0	90. 01
91. 00 09100 EMERGENCY	15, 668	16, 963	0	2, 591	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS				ما		05.00
95. 00 09500 AMBULANCE SERVI CES	0	l .	0	0 0	0	95. 00 101. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	l ol	U	U _I	0	101.00
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	o	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	153, 662	79, 784	0	254, 478		118. 00
NONREI MBURSABLE COST CENTERS		· · · · · ·		· '		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
192. 01 19201 PV WABASH HEALTH CLINC-CASS	0	0	0	0		192. 01
192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0		192. 02
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	0		192. 03
194. 00 07950 FI TNESS CENTER	0	0	0	0		194. 00
194. 01 07951 FOUNDATION	0	0	0	0		194. 01
194. 02 07952 NEW DIRECTION	0	0	0	0		194. 02 194. 03
194.03 07953 COMMUNITY & VOLUNTEER SERVICES 194.04 07956 OTHER NONREIMBURSABLE COST CENTERS	0		0	0		194. 03
194. 05 07955 OCCUPATI ONAL HEALTH	0		0	0		194. 04
200.00 Cross Foot Adjustments		1 1		Ĭ	O	200. 00
201.00 Negative Cost Centers	0	o	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	153, 662	79, 784	0	254, 478		202. 00
			·			

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

				To	0 12/31/2018 Part 11 Date/Time Pr 4/27/2020 11	epared:
	Cost Center Description	Subtotal	Intern &	Total	4/2//2020 11	: US alli
		F	Residents Cost & Post			
			Stepdown			
		24.00	Adjustments	27, 00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 00	OO4OO					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVI CES & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	801, 102	0	801, 102		30. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	13, 393	0	13, 393		43. 00
50. 00	05000 OPERATING ROOM	488, 623	o	488, 623		50.00
51.00	05100 RECOVERY ROOM	o	О	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	61, 089	0	61, 089		52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 721 413, 746	0	3, 721 413, 746		53. 00 54. 00
56. 00	05600 RADI OI SOTOPE	413,740	Ö	413, 740		56.00
60.00	06000 LABORATORY	232, 376	О	232, 376		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	152, 677 13, 249	0	152, 677 13, 249		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	9, 675	ő	9, 675		68. 00
	06900 ELECTROCARDI OLOGY	187, 723	О	187, 723		69. 00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	28, 700	0	28, 700		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	32, 651 462, 637	0	32, 651 462, 637		72. 00 73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	13	ő	13		76. 98
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C 09001 SENI OR CARE	11, 630 71, 289	0	11, 630 71, 289		90. 00 90. 01
	09100 EMERGENCY	392, 684	o	392, 684		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,2,33.	Ö	072,001		92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	0	0	0		95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u></u> Ο _Ι	O _I		1101.00
	11300 I NTEREST EXPENSE					113. 00
	11600 HOSPI CE	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 376, 978	0	3, 376, 978		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	27, 371	0	27, 371		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	19, 008	0	19, 008		192. 00
	19201 PV WABASH HEALTH CLINC-CASS 19202 PV WABASH HEALTH CLINC-N. MANCH	113, 929	0	113, 929		192. 01 192. 02
	19203 PV WABASH HEALTH CLINC-N. WANCH	92, 276 80, 637	0	92, 276 80, 637		192. 02
	07950 FITNESS CENTER	0	Ö	0		194. 00
	07951 FOUNDATION	16, 098	0	16, 098		194. 01
	07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES	0	0	0		194. 02 194. 03
	07956 OTHER NONREIMBURSABLE COST CENTERS	5, 411 0	0	5, 411 0		194. 03
	07955 OCCUPATI ONAL HEALTH	25, 367	Ö	25, 367		194. 05
200.00		0	0	0		200. 00
201. 00 202. 00		0 3, 757, 075	0	0 3, 757, 075		201. 00 202. 00
202.00		3, /3/, 0/5	0	3, 131, 0/5		1202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1310 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 4/27/2020 11:05 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 89 937 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 89, 937 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,931 1, 931 11, 625, 803 4.00 00500 ADMINISTRATIVE & GENERAL 4, 020, 366 5 00 28, 411 -13, 477, 464 27 938 364 5 00 28 411 7.00 00700 OPERATION OF PLANT 5,844 5, 844 302, 360 1, 224, 093 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 2,058 2,058 251, 455 0 9.00 9.00 646, 743 0 01000 DI ETARY 99, 489 305, 272 10 00 10.00 3.436 3.436 11.00 01100 CAFETERI A 2, 476 2, 476 394, 839 0 874, 312 11.00 01300 NURSING ADMINISTRATION 1, 127 307, 997 13.00 1, 127 448, 576 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 \cap 0 15.00 01500 PHARMACY 4.587 4, 587 695, 032 965, 523 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 809, 262 30.00 1, 563, 982 9,673 9,673 30.00 43.00 04300 NURSERY 52 52 31, 982 0 152, 982 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 885 8, 885 642, 679 0 1, 760, 866 50.00 05100 RECOVERY ROOM 51.00 0 0 51, 00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 425 425 124, 675 603, 335 52.00 05300 ANESTHESI OLOGY 0 53.00 86 86 2,716 53.00 1, 954, 753 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 727 829, 579 0 6.727 54.00 56.00 05600 RADI OI SOTOPE 0 0 56,00 60.00 06000 LABORATORY 3, 253 3, 253 0 1, 660, 685 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 66.00 06600 PHYSI CAL THERAPY 473 473 789, 795 1, 040, 098 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 115, 150 164, 120 67.00 06800 SPEECH PATHOLOGY 82, 148 117,083 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 275 3, 275 467, 593 0 750, 155 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 433, 888 71 00 \cap 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 493, 633 72.00 C 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 3, 382, 317 73.00 07698 HYPERBARI C OXYGEN THERAPY 199 76.98 76.98 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 57 57 5, 719 0 140, 613 90.00 90. 01 09001 SENIOR CARE 1, 246 1, 246 127, 921 0 304, 135 90.01 09100 EMERGENCY ol 91 00 4 225 4 225 609 517 2, 937, 077 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 С 0 95.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 88, 247 88, 247 -13, 477, 464 23, 172, 436 118. 00 118.00 11, 462, 278 NONREIMBURSABLE COST CENTERS 67, 840 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 599 37, 971 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 277, 482 192. 00 0 125, 554 0 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 1, 722, 419 192. 01 0 0 C 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 1, 395, 061 192. 02 0 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 Ω 1, 219, 099 192. 03 194.00 07950 FITNESS CENTER 0 0 0 194 00 C 0 12, 642 194. 01 194. 01 07951 FOUNDATI ON 403 403 0 194.02 07952 NEW DIRECTION 0 0 0 194. 02 0 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 51, 465 194. 03 53 53 0 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 0 194.04 194. 05 07955 OCCUPATIONAL HEALTH 0 19, 920 194. 05 635 635 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 611, 594 1, 209, 702 3, 219, 078 13, 477, 464 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17. 919143 13. 450549 0. 276891 0. 482400 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 847, 972 204. 00 60, 575 Part II) 205.00 0.005210 0.066145 205.00 Unit cost multiplier (Wkst. B, Part II)206.00 NAHE adjustment amount to be allocated 206, 00 (per Wkst. B-2)

Health Financial Systems PA	ARKVIEW WABASH I	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 4/27/2020 11:	pared: 05 am
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	& GENERAL (ACCUM. COST)	
	1.00	2.00	4. 00	5A	5. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1310 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 4/27/2020 11:05 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (MEALS SERVED) PLANT LINEN SERVICE (HOURS) (SQUARE FEET) (POUNDS OF LAUNDR) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 59, 648 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 2.058 57, 590 9.00 10.00 01000 DI ETARY 3, 436 3, 436 2,711 10.00 01100 CAFETERI A 2, 476 2, 476 9,866 11.00 11.00 01300 NURSING ADMINISTRATION 0 374 13.00 13.00 1, 127 1, 127 0 14.00 01400 CENTRAL SERVICES & SUPPLY C 0 0 14.00 15.00 01500 PHARMACY 4,587 4, 587 852 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 9,673 2, 711 2,740 30.00 9.673 04300 NURSERY 43.00 0 0 43.00 52 52 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8,885 0 8,885 986 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 425 0 425 52.00 0 05300 ANESTHESI OLOGY 0 53 00 86 86 0 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 6,727 0 6,727 1,501 54.00 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 0 60 00 06000 LABORATORY 3 150 Ω 60 00 3, 150 0 |06300| BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 1, 253 06600 PHYSI CAL THERAPY 66.00 6.473 6.473 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 94 67.00 0 C 06800 SPEECH PATHOLOGY 68 00 91 68 00 0 0 06900 ELECTROCARDI OLOGY 69.00 3, 275 3, 275 747 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 0 C 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 Ω 0 73 00 0 07698 HYPERBARIC OXYGEN THERAPY 76. 98 0 0 0 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 57 57 0 90.00 09001 SENI OR CARE 90.01 213 90.01 1.246 0 1.246 0 91.00 09100 EMERGENCY 4, 225 4, 225 0 1,006 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 0 Λ O 0 Λ 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 958 0 55, 900 2,711 9, 866 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 599 599 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 0 192. 01 0 0 0 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 192, 02 0 0 0 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 0 192. 03 194.00 07950 FITNESS CENTER 0 C 0 194.00 0 194. 01 07951 FOUNDATI ON 0 194. 01 403 403 194. 02 07952 NEW DIRECTION 0 194. 02 0 Ω 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 53 53 0 194. 03 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 04 C 194. 05 07955 OCCUPATIONAL HEALTH ol 0 194.05 635 635 200.00 Cross Foot Adjustments 200. 00 201. 00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 1, 814, 595 1, 021, 340 618, 000 1, 415, 315 202. 00 Part I) 17. 734676 143. 453781 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 30 421724 0.000000 227. 960162 204.00 Cost to be allocated (per Wkst. B, 265, 867 117, 821 150, 841 153, 662 204. 00 Part II) 15. 574904 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 4. 457266 0.000000 2.045859 55.640354 II) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207. 00 Parts III and IV)

		PARKVIEW WABASH H				u of Form CMS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CC	:N: 15-1310 P	eriod: rom 01/01/2018	Worksheet B-1
				Τ	o 12/31/2018	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	4/27/2020 11:05 am
	cost center bescription	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT NRS	(COSTED		(GROSS REV)	
		I NG HR)	REQUIS.)	15.00	14.00	
GENER	AL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	
	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2. 00
1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
	ADMINISTRATIVE & GENERAL OPERATION OF PLANT					5. 00 7. 00
	LAUNDRY & LINEN SERVICE					8. 00
	HOUSEKEEPI NG					9. 00
	DIETARY					10.00
	CAFETERI A					11.00
	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	98, 719	0			13. 00 14. 00
	PHARMACY		o	188, 795		15. 00
	MEDICAL RECORDS & LIBRARY	o	Ö	0		16. 00
	IENT ROUTINE SERVICE COST CENTERS					
4	ADULTS & PEDI ATRI CS	50, 269	0	4, 928		
	NURSERY LARY SERVICE COST CENTERS	1, 407	0	1	0	43.00
	OPERATING ROOM	20, 570	ol	238	0	50.00
	RECOVERY ROOM	0	Ö	0		51. 00
	DELIVERY ROOM & LABOR ROOM	5, 484	0	3	0	52. 00
4	ANESTHESI OLOGY	0	0	211	0	53.00
	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	0	0	1, 468	0	54. 00 56. 00
	LABORATORY		0	0	0	60.00
	BLOOD STORING, PROCESSING & TRANS.	o	Ö	0	0	63.00
	PHYSI CAL THERAPY	0	0	2, 461	l	66. 00
	OCCUPATIONAL THERAPY	0	0	244		67.00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	64	0	68. 00 69. 00
4	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	o	71. 00
	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72. 00
	DRUGS CHARGED TO PATIENTS	0	0	177, 255		73. 00
	HYPERBARIC OXYGEN THERAPY TIENT SERVICE COST CENTERS	0	0	0	0	76. 98
	CLINIC	0	O	0	0	90.00
	SENI OR CARE	0	O	0	O	90. 01
	EMERGENCY	20, 989	0	1, 922	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART					92.00
05 00 00500	REIMBURSABLE COST CENTERS AMBULANCE SERVICES	0	ol	0	O	95. 00
	HOME HEALTH AGENCY	0	o	0		
SPECI	AL PURPOSE COST CENTERS					
	I NTEREST EXPENSE					113.00
116. 00 11600 118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	98, 719	0	188, 795	0	116. 00 118. 00
	IMBURSABLE COST CENTERS	70, 717	<u> </u>	100, 773	<u> </u>	110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190. 00
	PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	-	192. 00
	PV WABASH HEALTH CLINC-CASS PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0	192. 01 192. 02
	PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0	192. 03
4	FITNESS CENTER	Ö	o	0	O	194. 00
194. 01 07951	FOUNDATI ON	0	0	0	O	194. 01
	NEW DIRECTION	0	0	0	0	194. 02
	COMMUNITY & VOLUNTEER SERVICES OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194. 03 194. 04
	OCCUPATIONAL HEALTH	0	0	0	0	194. 05
200. 00	Cross Foot Adjustments		J	O		200. 00
201. 00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	772, 893	0	1, 774, 407	0	202. 00
203. 00	Part Unit cost multiplier (Wkst. B, Part)	7. 829222	0. 000000	9. 398591	0. 000000	203.00
203.00	Cost to be allocated (per Wkst. B,	7, 829222	0. 000000 N	9. 398591 254, 478		204. 00
	Part II)	,,,,,,,,,	J	201, 770		254.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 808193	0. 000000	1. 347906	0. 000000	205. 00
		1				206. 00
206 UUI	TIME and astiment amount to be allocated				1	J200. 00
206. 00	(per Wkst. B-2)					
206. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

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:	Worksheet C

From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 4/27/2020 11:05 am Title XVIII Hospi tal Cost Costs Total Cost Cost Center Description Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 6, 081, 214 30 00 6, 081, 214 Ω 43.00 04300 NURSERY 240, 310 240, 310 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 342, 907 3, 342, 907 50.00 0 05100 RECOVERY ROOM 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 957, 813 957, 813 0 0 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 10, 150 10, 150 53.00 3, 450, 795 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 450, 795 54.00 Λ 56.00 05600 RADI OI SOTOPE 0 56.00 60.00 06000 LABORATORY 2, 613, 491 2, 613, 491 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 06600 PHYSI CAL THERAPY 2, 056, 436 66.00 2, 056, 436 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 259, 069 259, 069 0 67.00 06800 SPEECH PATHOLOGY 68.00 187, 220 187, 220 0 68.00 1, 376, 902 06900 ELECTROCARDI OLOGY 69.00 69 00 1 376 902 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 643, 196 643, 196 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 731, 762 731, 762 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 6, 679, 892 6, 679, 892 0 73.00 07698 HYPERBARI C OXYGEN THERAPY o 76. 98 295 295 Ω 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 212, 481 212, 481 0 0 90.00 0 90 01 09001 SENI OR CARE 541 408 541, 408 Ω 90.01 0 91.00 09100 EMERGENCY 4, 884, 091 4, 884, 091 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 825, 363 1, 825, 363 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 n 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116, 00 200.00 Subtotal (see instructions) 36, 094, 795 0 36, 094, 795 0 0 200. 00 201.00 1, 825, 363 1, 825, 363 0 201. 00 Less Observation Beds 0 202.00 202.00 Total (see instructions) 34, 269, 432 34, 269, 432

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	

Health Financial Systems	PA	ARKVIEW WABASH E	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS	TO CHARGES		Provi der CO		Peri od:	Worksheet C	
					rom 01/01/2018		
				1	To 12/31/2018	Date/Time Pre	
						4/27/2020 11:0	05 am_
		_		XVIII	Hospi tal	Cost	
			Charges				
Cost Center Descri	ption	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVIC	E COST CENTERS						
30. 00 03000 ADULTS & PEDIATRIC	S	4, 725, 294		4, 725, 294	1		30.00
43. 00 04300 NURSERY		59, 610		59, 610			43.00
ANCILLARY SERVICE COST C	ENTERS	<u> </u>			<u>'</u>		
50. 00 05000 OPERATING ROOM		931, 218	9, 379, 832	10, 311, 050	0. 324206	0.000000	50.00
51.00 05100 RECOVERY ROOM		0	0		0. 000000	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LAI	BOR ROOM	232, 374	0	232, 374		0. 000000	
53. 00 05300 ANESTHESI OLOGY	2011 1100	123, 395	1, 364, 532			0. 000000	•
54. 00 05400 RADI OLOGY - DI AGNOST	I C	1, 275, 401	25, 729, 557	27, 004, 958		0. 000000	
56. 00 05600 RADI 0L001 - DI AGNOST	10	1, 273, 401	23, 724, 337	21,004,930	0. 127784	0.000000	
60. 00 06000 LABORATORY		1 5/2 227	- 1	15 074 270		0.000000	
	CECCING & TRANC	1, 562, 227	13, 512, 143	15, 074, 370			
63. 00 06300 BLOOD STORING, PRO	CESSING & TRANS.	0	0	(0.000000	0. 000000	
66. 00 06600 PHYSI CAL THERAPY		223, 052	3, 412, 611	3, 635, 663		0. 000000	
67. 00 06700 OCCUPATI ONAL THERA	PY	139, 164	205, 965	345, 129		0. 000000	
68.00 06800 SPEECH PATHOLOGY		33, 691	108, 513	142, 204		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY		1, 327, 489	3, 188, 452	4, 515, 941	0. 304898	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES C	HARGED TO PATIENT	223, 484	1, 733, 335	1, 956, 819	0. 328695	0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED	TO PATIENTS	180, 782	2, 439, 365	2, 620, 147	0. 279283	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PA	ATI ENTS	2, 731, 552	19, 009, 217	21, 740, 769	0. 307252	0.000000	73. 00
76. 98 07698 HYPERBARI C OXYGEN	THERAPY	1, 337	0	1, 337	0. 220643	0.000000	76. 98
OUTPATIENT SERVICE COST	CENTERS	<u> </u>			<u>'</u>		
90. 00 09000 CLINIC		0	963, 934	963, 934	0. 220431	0.000000	90.00
90. 01 09001 SENI OR CARE		0	626, 114	626, 114		0.000000	
91. 00 09100 EMERGENCY		804, 441	17, 218, 027	18, 022, 468		0. 000000	
92. 00 09200 OBSERVATI ON BEDS (1	NON-DISTINCT PART	00.7.11	1, 889, 316	1, 889, 316		0. 000000	1
OTHER REIMBURSABLE COST		9	1,007,010	1,007,010	0. 700 100	0.00000	72.00
95. 00 09500 AMBULANCE SERVICES		0	0	(0.000000	0. 000000	95. 00
101.00 10100 HOME HEALTH AGENCY		0	0	(0.000000	101.00
SPECIAL PURPOSE COST CEN		<u> </u>	O		7		1101.00
113. 00 11300 NTEREST EXPENSE	TERS						113. 00
116. 00 11600 HOSPI CE		n	Ω	(116. 00
200.00 Subtotal (see inst	ructions)	14, 574, 511	100, 780, 913	115, 355, 424	í		200.00
201.00 Less Observation B		14, 3/4, 311	100, 700, 713	110, 333, 425	1		201.00
202.00 Total (see instruction in the contraction in		14, 574, 511	100, 780, 913	115, 355, 424			201.00
ZUZ. UU TUTAL (See HISTIAC	11 0115)	14, 3/4, 511	100, 700, 913	110, 300, 424	*		1202.00

cost center bescription [FF3 inpatrent]	
Rati o	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
	0. 00
	3. 00
ANCILLARY SERVICE COST CENTERS	
	0. 00
51. 00 05100 RECOVERY ROOM 0. 000000 51	1. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52	2. 00
53. 00 05300 ANESTHESI 0LOGY 0. 000000 53	3. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 000000 54	4. 00
56. 00 05600 RADI 0I SOTOPE 0. 000000 56	6. 00
60. 00 06000 LABORATORY 0. 000000 60	O. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 000000 63	3. 00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66	6. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67	7. 00
68. 00 06800 SPEECH PATHOLOGY 0. 000000 68	8. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69	9. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 000000 71	1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72	2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73	3. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76	6. 98
OUTPATIENT SERVICE COST CENTERS	
90. 00	O. 00
90. 01 09001 SENI OR CARE 0. 000000 90	0. 01
91. 00 09100 EMERGENCY 0. 000000 91	1. 00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92	2. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 0. 000000 95	5. 00
101. 00 10100 HOME HEALTH AGENCY 101	1. 00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300 I NTEREST EXPENSE 113	3. 00
116. 00 11600 H0SPI CE 116	6. 00
200.00 Subtotal (see instructions) 200	0. 00
201.00 Less Observation Beds 201	1. 00
202. 00 Total (see instructions)	2. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-1310		B Date/Time Prepared: 4/27/2020 11:05 am		
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	6, 081, 214		6, 081, 2	14 0	6, 081, 214	30. 00
	04300 NURSERY	240, 310		240, 3		240, 310	
43.00	ANCI LLARY SERVI CE COST CENTERS	240, 310		240, 3	10 0	240, 310	43.00
50. 00	05000 OPERATING ROOM	3, 342, 907		3, 342, 9	07	3, 342, 907	50. 00
51. 00	05100 RECOVERY ROOM	3, 342, 707		3, 342, 3		3, 342, 707	51.00
	05200 DELIVERY ROOM & LABOR ROOM	957, 813		957, 8	13	957, 813	
53. 00	05300 ANESTHESI OLOGY	10, 150		10, 1	1	10, 150	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 450, 795		3, 450, 7		3, 450, 795	
56. 00	05600 RADI OI SOTOPE	3, 430, 773		3, 430, 7	0	0, 430, 773	
60. 00	06000 LABORATORY	2, 613, 491		2, 613, 4	91 0	2, 613, 491	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	2,010,171		2,010,1	, 0	2,010,171	63. 00
66. 00	06600 PHYSI CAL THERAPY	2, 056, 436	0	2, 056, 4	36 0	2, 056, 436	
67. 00	06700 OCCUPATI ONAL THERAPY	259, 069	0	259, 0		259, 069	
68. 00	06800 SPEECH PATHOLOGY	187, 220	0	187, 2		187, 220	
	06900 ELECTROCARDI OLOGY	1, 376, 902	_	1, 376, 9		1, 376, 902	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	643, 196		643, 1		643, 196	
	07200 IMPL. DEV. CHARGED TO PATIENTS	731, 762		731, 7		731, 762	
	07300 DRUGS CHARGED TO PATIENTS	6, 679, 892		6, 679, 8		6, 679, 892	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	295			95 0	295	
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	212, 481		212, 4	31 0	212, 481	90. 00
90. 01	09001 SENI OR CARE	541, 408		541, 4	0 80	541, 408	90. 01
91.00	09100 EMERGENCY	4, 884, 091		4, 884, 0	91 0	4, 884, 091	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 825, 363		1, 825, 3	53	1, 825, 363	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0			0	0	
101.00	10100 HOME HEALTH AGENCY	0			0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0			0		116. 00
200.00		36, 094, 795	0			36, 094, 795	
201.00	1	1, 825, 363	_	1, 825, 3		1, 825, 363	
202. 00	Total (see instructions)	34, 269, 432	0	34, 269, 4	32 0	34, 269, 432	202.00

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

From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 4/27/2020 11:05 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 725, 294 4, 725, 294 30.00 30.00 43.00 04300 NURSERY 59, 610 59, 610 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 931, 218 9, 379, 832 10, 311, 050 0.324206 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 232, 374 232, 374 4. 121860 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 123, 395 1, 364, 532 1, 487, 927 0.006822 0.000000 53.00 25, 729, 557 05400 RADI OLOGY-DI AGNOSTI C 0.127784 0.000000 54.00 1, 275, 401 27, 004, 958 54.00 56.00 05600 RADI OLSOTOPE 0.000000 0.000000 56 00 13, 512, 143 60.00 06000 LABORATORY 1, 562, 227 15, 074, 370 0.173373 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 06600 PHYSI CAL THERAPY 3, 412, 611 3, 635, 663 66.00 223.052 0.565629 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 139, 164 205, 965 345, 129 0.750644 0.000000 67.00 06800 SPEECH PATHOLOGY 33, 691 108, 513 142, 204 1. 316559 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 327, 489 3, 188, 452 4, 515, 941 0. 304898 0.000000 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 223.484 1, 733, 335 1. 956, 819 0.328695 71 00 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 180, 782 2, 439, 365 2, 620, 147 0. 279283 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 731, 552 21, 740, 769 0.307252 0.000000 73.00 19, 009, 217 73.00 07698 HYPERBARI C OXYGEN THERAPY 1, 337 0.220643 0.000000 76.98 1.337 76.98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 963, 934 963, 934 0.220431 0.000000 90.00 09001 SENIOR CARE 90. 01 0 626, 114 626, 114 0.864712 0.000000 90.01 91 00 09100 EMERGENCY 804.441 17, 218, 027 18, 022, 468 0 271000 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 1, 889, 316 1, 889, 316 0.966150 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116 00 200.00 Subtotal (see instructions) 14, 574, 511 100, 780, 913 115, 355, 424 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 14, 574, 511 100, 780, 913 115, 355, 424 202.00

				10 12/31/2018	4/27/2020 11:0	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30. 00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
	O5000 OPERATING ROOM	0. 324206				50. 00
	05100 RECOVERY ROOM	0. 000000				51. 00
	D5200 DELIVERY ROOM & LABOR ROOM	4. 121860				52. 00
	05300 ANESTHESI OLOGY	0. 006822				53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0. 127784				54. 00
	D5600 RADI OI SOTOPE	0. 000000				56. 00
	06000 LABORATORY	0. 173373				60. 00
1	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
1	06600 PHYSI CAL THERAPY	0. 565629				66. 00
	06700 OCCUPATI ONAL THERAPY	0. 750644				67. 00
	06800 SPEECH PATHOLOGY	1. 316559				68. 00
	06900 ELECTROCARDI OLOGY	0. 304898				69. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328695				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 279283				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 307252				73. 00
	07698 HYPERBARIC OXYGEN THERAPY	0. 220643				76. 98
	DUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 220431				90. 00
	09001 SENLOR CARE	0. 864712				90. 01
	09100 EMERGENCY	0. 271000				91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 966150				92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0. 000000				95. 00
	10100 HOME HEALTH AGENCY					101. 00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113. 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 PARKVIEW WABA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1310

					10 12/31/2016	4/27/2020 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	l Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	3, 342, 907	488, 623	2, 854, 28	4 0	0	50.00
51.00 05	5100 RECOVERY ROOM	0	0		0	0	51.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	957, 813	61, 089	896, 72	4 0	0	52. 00
53.00 05	5300 ANESTHESI OLOGY	10, 150	3, 721	6, 42	9 0	0	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	3, 450, 795	413, 746	3, 037, 04	9 0	0	54.00
56. 00 05	5600 RADI OI SOTOPE	0	0		0	0	56. 00
60.00 06	6000 LABORATORY	2, 613, 491	232, 376	2, 381, 11	5 0	0	60.00
63.00 06	6300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
66. 00 06	6600 PHYSI CAL THERAPY	2, 056, 436	152, 677	1, 903, 75	9 0	0	66. 00
67. 00 06	5700 OCCUPATIONAL THERAPY	259, 069	13, 249	245, 82	0	0	67. 00
68. 00 06	5800 SPEECH PATHOLOGY	187, 220	9, 675	177, 54	5 0	0	68. 00
69. 00 06	5900 ELECTROCARDI OLOGY	1, 376, 902	187, 723	1, 189, 17	9 0	0	69. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	643, 196	28, 700	614, 49	6 0	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	731, 762	32, 651	699, 11	1 0	0	72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	6, 679, 892	462, 637	6, 217, 25	5 0	0	73. 00
76. 98 07	7698 HYPERBARIC OXYGEN THERAPY	295	13	28	2 0	0	76. 98
OU	JTPATIENT SERVICE COST CENTERS				•	•	
90.00 09	9000 CLI NI C	212, 481	11, 630	200, 85	1 0	0	90.00
90. 01 09	9001 SENLOR CARE	541, 408	71, 289	470, 11	9 0	0	90. 01
91.00 09	9100 EMERGENCY	4, 884, 091	392, 684	4, 491, 40	7 0	0	91. 00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART	1, 825, 363	240, 462	1, 584, 90	1 0	0	92.00
	THER REIMBURSABLE COST CENTERS			, ,			
	9500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
	D100 HOME HEALTH AGENCY	o	0		0	0	101. 00
	PECIAL PURPOSE COST CENTERS				-		
	1300 INTEREST EXPENSE						113. 00
	1600 HOSPI CE	0	0		0	l .	116. 00
200. 00	Subtotal (sum of lines 50 thru 199)	29, 773, 271	2, 802, 945	26, 970, 32	6 0		200. 00
201. 00	Less Observation Beds	1, 825, 363	240, 462				201. 00
202. 00	Total (line 200 minus line 201)	27, 947, 908	2, 562, 483				202. 00
_02.00	1.112. (1.110 200 1.100 1.110 201)	2.7,700	2,002,100	20,000, 12	-1		

| Peri od: | Worksheet C | From 01/01/2018 | Part II | Date/Time Prepared: | 4/27/2020 11:05 am

						4/27/2020 11	:05 am_
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charg	ge		
		Operating Cost	Part I, column		6		
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	3, 342, 907	10, 311, 050	0. 32420	06		50.00
	D5100 RECOVERY ROOM	0	0	0.00000	00		51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	957, 813	232, 374	4. 12186	50		52. 00
53.00	D5300 ANESTHESI OLOGY	10, 150	1, 487, 927	0. 00682	22		53. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	3, 450, 795	27, 004, 958	0. 12778	34		54.00
56.00	D5600 RADI OI SOTOPE	0	0	0. 00000	00		56. 00
60.00	06000 LABORATORY	2, 613, 491	15, 074, 370	0. 17337	73		60.00
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	00		63. 00
66.00	06600 PHYSI CAL THERAPY	2, 056, 436	3, 635, 663	0. 56562	29		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	259, 069	345, 129	0. 75064	14		67. 00
68.00	06800 SPEECH PATHOLOGY	187, 220	142, 204	1. 31655	59		68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 376, 902	4, 515, 941	0. 30489	98		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	643, 196	1, 956, 819	0. 32869	95		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	731, 762	2, 620, 147	0. 27928	33		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 679, 892	21, 740, 769	0. 30725	52		73. 00
76. 98	07698 HYPERBARIC OXYGEN THERAPY	295		0. 22064	13		76. 98
C	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	212, 481	963, 934	0. 22043	31		90.00
90. 01	09001 SENI OR CARE	541, 408	626, 114	0.8647	12		90. 01
91.00	09100 EMERGENCY	4, 884, 091	18, 022, 468	0. 27100	00		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 825, 363	1, 889, 316	0. 96615	50		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0.00000	00		95. 00
	10100 HOME HEALTH AGENCY	0	l o	0. 00000	00		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0. 00000	00		116. 00
200.00	Subtotal (sum of lines 50 thru 199)	29, 773, 271	110, 570, 520				200. 00
201.00	Less Observation Beds	1, 825, 363		,			201. 00
202. 00	Total (line 200 minus line 201)	27, 947, 908		,			202. 00
	1				1		1

Health Financial Systems	PARKVIEW WABASH HOS	SPI TA	L, II	NC.		In Lie	u of Form CMS-255	2-10
ABBODEL CAMPELLE OF LABOUE FAIR	NATIONAL OF THE COURT			0.011 45 4040	D			

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 4/27/2020 11:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	Related Cost			Program	(column 3 x	
	(from Wkst. B,	· ·	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	488, 623				'	
51.00 05100 RECOVERY ROOM	C	1	0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	61, 089		1		0	52. 00
53. 00 05300 ANESTHESI OLOGY	3, 721		1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	413, 746	27, 004, 958			6, 210	
56. 00 05600 RADI 0I SOTOPE	C	1	0.00000		0	56. 00
60. 00 06000 LABORATORY	232, 376	15, 074, 370			8, 770	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C) C	0.00000	0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	152, 677	3, 635, 663	0. 04199	4 101, 664	4, 269	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 249	345, 129	0. 03838	9 61, 204	2, 350	67. 00
68.00 06800 SPEECH PATHOLOGY	9, 675	142, 204	0. 06803	6 13, 455	915	68. 00
69. 00 06900 ELECTROCARDI OLOGY	187, 723	4, 515, 941	0. 04156	9 601, 078	24, 986	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 700	1, 956, 819	0. 01466	7 105, 006	1, 540	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 651	2, 620, 147	0. 01246	2 22, 028	275	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	462, 637	21, 740, 769	0. 02128	0 1, 019, 479	21, 695	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	13	1, 337	0. 00972	3 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		•			1
90. 00 09000 CLI NI C	11, 630	963, 934	0. 01206	5 0	0	90.00
90. 01 09001 SENI OR CARE	71, 289	626, 114	0. 11385	9 0	0	90. 01
91. 00 09100 EMERGENCY	392, 684	18, 022, 468	0. 02178	9 49, 263	1, 073	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	240, 462	1, 889, 316	0. 12727	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	•	•	•		1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	2, 802, 945	110, 570, 520		3, 139, 867	80, 431	200. 00

Health Financial Systems	PARKVIEW WABASH HOS	In Lieu of Form CMS-255		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	

				-	Го 12/31/2018	Date/Time Pre 4/27/2020 11:	
				XVIII	Hospi tal	Cost	
	Cost Center Description			Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(0	0	50. 00
	05100 RECOVERY ROOM	0	0		0	0	51. 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
	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	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90.00
90. 01	09001 SENI OR CARE	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310		Worksheet D
			From 01/01/2010	Dont IV

THROUGH COSTS From 01/01/2018 | Part IV To 12/31/2018 | Date/Time Prepared: 4/27/2020 11:05 am Title XVIII Hospi tal Cost All Other Total Cost Ratio of Cost Cost Center Description Total Total Charges to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, and 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 10, 311, 050 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 51. 00 | 05100 | RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 232, 374 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 0 1, 487, 927 0.000000 53.00 OI 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 27, 004, 958 0.000000 54.00 0 56.00 05600 RADI 0I S0T0PE 0 0.000000 56.00 60.00 06000 LABORATORY 15, 074, 370 0.000000 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63 00 06600 PHYSI CAL THERAPY 0 0.000000 66.00 3, 635, 663 66.00 67.00 06700 OCCUPATIONAL THERAPY 345, 129 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 142, 204 68.00 06900 ELECTROCARDI OLOGY 4, 515, 941 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 1, 956, 819 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 620, 147 0.000000 72.00 72.00 21, 740, 769 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73 00 0 73 00 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 1, 337 0.000000 76. 98 OUTPATIENT SERVICE COST CENTERS 0 0.000000 90.00 09000 CLI NI C 0 963, 934 90.00 09001 SENI OR CARE 0 0.000000 90. 01 Ω 90.01 626, 114 0 0 91.00 09100 EMERGENCY 0 18, 022, 468 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 889, 316 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 200.00 Total (lines 50 through 199) 110, 570, 520 200.00

Heal th	Financial Systems PA	ARKVIEW WABASH H	IOSPITAL, INC.		In Li∈	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS			CN: 15-1310	Period: From 01/01/2018 To 12/31/2018		
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	T	9. 00	10.00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	0. 000000	175, 248		0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	17, 203		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	405, 325		0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
60.00	06000 LABORATORY	0. 000000	568, 914		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	101, 664		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	61, 204		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	13, 455		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	601, 078		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	105, 006		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	22, 028		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 019, 479		0 0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS]
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
00 01	DOGGA CENT OF CAPE	0 000000				1	00 04

0. 000000 0. 000000 0. 000000 0. 000000

49, 263

3, 139, 867

0 0 0

0

0 0 0

0

95. 00 0 200. 00

0 90. 01

0 91.00

0 92.00

90. 00 | 09000 | CEINIC 90. 01 | 09001 | SENIOR CARE 91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C	CN: 15-1310	Period: From 01/01/2018 To 12/31/2018		pared: 05 am
			Titl∈	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		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.)		
	T	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			T			
50. 00	05000 OPERATING ROOM	0. 324206			0 2, 100, 847	0	
51.00	05100 RECOVERY ROOM	0. 000000	l .		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4. 121860	0		0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 006822	0		0 295, 420	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 127784	l .		0 7, 804, 010	0	
56. 00	05600 RADI OI SOTOPE	0. 000000			0	0	56. 00
60.00	06000 LABORATORY	0. 173373			0 4, 046, 120	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0	0	63. 00
66.00	06600 PHYSI CAL THERAPY	0. 565629	0		0 1, 191, 800	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 750644	0		0 51, 995	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1. 316559			0 37, 211	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 304898	0		0 1, 099, 607	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328695	0		0 310, 012	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 279283	0		0 628, 868	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 307252	0		0 7, 640, 577	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 220643	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 220431	0		0 0	0	90.00
90. 01	09001 SENI OR CARE	0. 864712	0		0 384, 900	0	90. 01
91.00	09100 EMERGENCY	0. 271000	0		0 3, 718, 117	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 966150	0		0 590, 933	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
200.00			0		0 29, 900, 417	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 29, 900, 417	0	202. 00

					То	12/31/2018	Date/Time Pre 4/27/2020 11:	
			Ti tl	e XVIII	H	lospi tal	Cost	
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Reimbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
			Ded. & Coins.					
		(see inst.)	(see inst.)	_				
lanc	LILLARY OFRITAE COOT OFFITERS	6. 00	7. 00					
	ILLARY SERVICE COST CENTERS		/04 40	-1				
	OO OPERATING ROOM	0	681, 10	1				50.00
	OO RECOVERY ROOM	0	9					51.00
	OO DELIVERY ROOM & LABOR ROOM	0	0.04	2				52.00
	OO ANESTHESI OLOGY	0	2, 01!					53.00
	OO RADI OLOGY-DI AGNOSTI C	0	997, 22	1				54.00
	OO RADI OI SOTOPE	0						56.00
	OO LABORATORY	0	701, 48	1				60.00
	00 BLOOD STORING, PROCESSING & TRANS.	0						63. 00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	674, 11 ³ 39, 030					66. 00 67. 00
	OO SPEECH PATHOLOGY	0	48, 990					68. 00
	OO ELECTROCARDI OLOGY	0	335, 26					69.00
	OO MEDICAL SUPPLIES CHARGED TO PATIENT	0	101, 89					71.00
	OO IMPL. DEV. CHARGED TO PATIENTS	0	175, 63	1				72.00
	OO DRUGS CHARGED TO PATIENTS	0	2, 347, 58	1				73. 00
	98 HYPERBARI C OXYGEN THERAPY	0						76. 98
	PATIENT SERVICE COST CENTERS	ı o		7				70. 70
90. 00 090		0						90.00
	01 SENI OR CARE	0	332, 82	-1				90. 01
	OO EMERGENCY	0	1, 007, 610	1				91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART	0	570, 930					92.00
	ER REIMBURSABLE COST CENTERS	<u> </u>	070,70	21				72.00
	00 AMBULANCE SERVICES	0						95. 00
200.00	Subtotal (see instructions)	l o	8, 015, 72	5				200.00
201. 00	Less PBP Clinic Lab. Services-Program	O	5,5.5,72					201.00
	Only Charges							
202. 00	Net Charges (line 200 - line 201)	o	8, 015, 72	5				202.00
,	•	,	•	•				•

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

From 01/01/2018 Part V
To 12/31/2018 Date/Time Prepared: Component CCN: 15-Z310 4/27/2020 11:05 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. 324206 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 4 121860 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.006822 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127784 0 54.00 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 0 06000 LABORATORY 0 60.00 0.173373 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 06600 PHYSI CAL THERAPY 0 66.00 0.565629 0 66.00 06700 OCCUPATIONAL THERAPY 0. 750644 0 67 00 67 00 0 06800 SPEECH PATHOLOGY 68.00 1. 316559 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 304898 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0. 328695 0 71.00 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 279283 0 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 0.307252 0 0 73.00 07698 HYPERBARI C OXYGEN THERAPY 0. 220643 0 76. 98 76. 98 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 220431 0 0 90.00 0 0 0 90.01 09001 SENI OR CARE 0.864712 0 0 90.01 91.00 09100 EMERGENCY 0. 271000 0 0 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 966150 92.00 92.00 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 0 0 200.00 200.00 Subtotal (see instructions) 0 Less PBP Clinic Lab. Services-Program 0 201.00 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00

Health Financial Systems P	Systems PARKVIEW WABASH HOSPITAL, INC.					In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	OTHER HEALTH SERVICES AND VACCINE COST		CN: 15-1310 CCN: 15-Z310	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 4/27/2020 11:			
		Title	XVIII	Swing Beds - SNF	Cost			
	Cos	sts						
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not						

		Co:	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.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	o o		54.00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
60.00	06000 LABORATORY	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66. 00	06600 PHYSI CAL THERAPY	0	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00		0	ol o		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	07698 HYPERBARI C OXYGEN THERAPY	0	ol o		76. 98
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	0		90.00
90. 01	09001 SENI OR CARE	0	0		90. 01
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS	•	•		
95.00	09500 AMBULANCE SERVICES	0			95. 00
200.0	O Subtotal (see instructions)	0	0		200. 00
201.0		0			201. 00
	Only Charges				
202.0		0	0	ol e e e e e e e e e e e e e e e e e e e	202. 00
	· · · · · · · · · · · · · · · · · · ·	•	•		•

Health Financial Systems PA	ARKVIEW WABASH	HOSPI T	AL, INC.		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Pro	Provider CCN: 15-1310		Peri od:	Worksheet D	
					From 01/01/2018 To 12/31/2018		narad.
					To 12/31/2018	4/27/2020 11:	
			Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swir	ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adj u	stment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-		Related Cost			
	Part II, col.			(col. 1 - col			
	26)			2)			
	1.00	2	. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	801, 102		6, 397	794, 70	5 3, 727	213. 23	30.00
43. 00 NURSERY	13, 393			13, 39	3 40	334. 83	43.00
200.00 Total (lines 30 through 199)	814, 495			808, 09	8 3, 767		200. 00
Cost Center Description	I npati ent	Inpa	ati ent				
	Program days	Pro	ogram				
		Capi t	al Cost				
		(col.	5 x col.				
			6)				
	6. 00	7	. 00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	27		5, 757				30. 00
43. 00 NURSERY	14		4, 688				43. 00
200.00 Total (lines 30 through 199)	41		10, 445				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

Health Financial Systems F	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 4/27/2020 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	488, 623		•		1, 674	
51. 00 05100 RECOVERY ROOM	0		0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	61, 089		•		0	52. 00
53. 00 05300 ANESTHESI OLOGY	3, 721				13	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	413, 746				614	
56. 00 05600 RADI 0I SOTOPE	0		0. 00000		0	56. 00
60. 00 06000 LABORATORY	232, 376	15, 074, 370			655	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0. 00000		0	63.00
66. 00 06600 PHYSI CAL THERAPY	152, 677		1		36	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 249		1		33	
68.00 06800 SPEECH PATHOLOGY	9, 675		1		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	187, 723	4, 515, 941	1		411	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 700	1, 956, 819	0. 01466	7 4, 872	71	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 651	2, 620, 147	0. 01246	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	462, 637	21, 740, 769	0. 02128	84, 237	1, 793	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	13	1, 337	0. 00972	23 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	11, 630	963, 934	0. 01206	5 0	0	90.00
90. 01 09001 SENI OR CARE	71, 289	626, 114	0. 11385	0	0	90. 01
91. 00 09100 EMERGENCY	392, 684	18, 022, 468	0. 02178	20, 138	439	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	240, 523	1, 889, 316	0. 12730	07	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	2, 803, 006	110, 570, 520)	243, 838	5, 739	200. 00

	PARKVIEW WABASH			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COST			Period: From 01/01/2018 To 12/31/2018		pared: 05 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY	0	0		0 0	0	43. 00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0	3, 72 4 3, 76	0. 00	27 14 41	30. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		57.13			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0 0					30. 00 43. 00 200. 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 01/01/2018	Part IV

	66616			1	o 12/31/2018	Date/Time Pre 4/27/2020 11:	pared: 05 am_
				e XIX	Hospi tal	PPS	
	Cost Center Description			Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	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 OI 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 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90. 00
90. 01	09001 SENI OR CARE	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D
TURQUOU COCTO			Erom 01/01/2010	Dart IV

APPORTI O THROUGH	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF COSTS	RVICE OTHER PASS	S Provi der C	1	Period: From 01/01/2018 To 12/31/2018		
			Ti tl	e XIX	Hospi tal	PPS	00 4
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	NCILLARY SERVICE COST CENTERS	1	Г	T			
	5000 OPERATING ROOM	0	0		10, 311, 050		
	5100 RECOVERY ROOM	0	0		0	0. 000000	51. 00
	5200 DELIVERY ROOM & LABOR ROOM	0	0		232, 374	0. 000000	
	5300 ANESTHESI OLOGY	0	0		1, 487, 927	0. 000000	
	5400 RADI OLOGY-DI AGNOSTI C	0	0		27, 004, 958		
	5600 RADI OI SOTOPE	0	0		0	0. 000000	
	6000 LABORATORY	0	0)	15, 074, 370		
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0)	0	0. 000000	
	6600 PHYSI CAL THERAPY	0	0)	3, 635, 663		
	6700 OCCUPATI ONAL THERAPY	0	0)	345, 129		
	6800 SPEECH PATHOLOGY	0	0)	142, 204		1
	6900 ELECTROCARDI OLOGY	0	0)	0 4, 515, 941	0. 000000	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	1, 956, 819		1
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	2, 620, 147		1
	7300 DRUGS CHARGED TO PATIENTS	0	0)	21, 740, 769		1
	7698 HYPERBARIC OXYGEN THERAPY	0	0)	1, 337	0.000000	76. 98
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0	0)	963, 934		1
90. 01 09	9001 SENI OR CARE	0	0)	0 626, 114	0.000000	90. 01
91. 00 09	9100 EMERGENCY	0	0)	18, 022, 468	0.000000	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	1, 889, 316	0.000000	92. 00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0) (110, 570, 520		200. 00

Health Financial Systems	PARKVIEW WABASH F	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	RY SERVICE OTHER PASS	Provi der Co	CN: 15-1310	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018	Part IV	
1111100011 00010				To 12/31/2018	Date/Time Pre	pared:
					4/27/2020 11:	05 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	

		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	, and the second	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	35, 333	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	5, 112	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	40, 084	0	0	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0	0	0	0	56. 00
60. 00 06000 LABORATORY	0. 000000	42, 466	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	860	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	858	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	9, 878	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 872	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	84, 237	0	0	0	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
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	20, 138	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		243, 838	0	0	0	200. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider Co	!	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 4/27/2020 11:	
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 324206	0	1	82, 156	0	
51.00 05100 RECOVERY ROOM	0. 000000	0	1	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4. 121860	0	1	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 006822	0	1	10, 934	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 127784	0	1	253, 868	0	54.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0)	0 0	0	56. 00
60. 00 06000 LABORATORY	0. 173373	0)	300, 906	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. 565629	0		23, 035	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 750644	0)	1, 379	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1. 316559	0)	7, 135	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 304898	0		8, 815	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 328695	0		16, 789	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 279283	0		6, 460	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 307252	0)	234, 954	0	73. 00
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 220643	0)	o	0	76. 98
OUTPATIENT SERVICE COST CENTERS						Ī
90. 00 09000 CLI NI C	0. 220431	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0. 864712	0	1	o	0	90. 01
91. 00 09100 EMERGENCY	0. 271000	0	1	277, 848	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 966150	0	1	12, 124	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 000000	0		O		95. 00
200.00 Subtotal (see instructions)		0	,	1, 236, 403	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	ı			ol ol		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		1, 236, 403	0	202. 00

Title XIX Hospital PPS					10 12/31/2018	Date/lime Prep 4/27/2020 11:0	pared: 05 am
Cost Center Description			Ti tl	e XIX	Hospi tal		
Relimbursed Services Sevices Sevic		Cost	ts				
Services Subject To Ded. & Colins Sub	Cost Center Description	Cost	Cost				
Subject To Ded. & Coins Code Inst. Ded.							
Ded, & Coins. Csee inst.							
See inst. (see inst.							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS 50.00							
50.00 05000 0PERATI NG ROOM 0 26,635 50.00 51.00 05100 0ECOVERY ROOM 0 0 0 0 0 0 0 0 0	ANOULL ADV. CEDVLOE, COCT, CENTERS	6.00	7.00				
51.00			0/ /05				F0 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 53. 00 05300 AMESTHES ID LOCY 0 75 53. 00 53. 00 05400 RABIO ID.GGY_DI AGNOSTI C 0 32, 440 54. 00 56. 00 65.		0	•				
53. 00 05300 ANESTHESI OLOGY 0 75 53. 00 54.00 63400 RADI OLOGY - DI AGNOSTI C 0 32,440 54. 00 56. 00 65600 RADI OLOGY - DI AGNOSTI C 0 0 0 0 60. 00 60.		0	0				
54. 00		0	75				
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0							
60. 00		0					
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 66.00 PHYSI CAL THERAPY 0 13,029 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 1,035 67.00 06700 OCCUPATI ONAL THERAPY 0 1,035 67.00 06900 SPECCH PATHOLOGY 0 9,394 68.00 06900 ELECTROCARDI OLOGY 0 2,688 69.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,518 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1,804 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 72,190 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 72,190 73.00 07409 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76.98 OUTPATI ENT SERVI CE COST CENTERS 0 0 0,000 O9000 CLI NI C 0 0 0 90.00 O9000 CLI NI C 0 0 0 90.00 O9000 SERVATI ON BEDS (NON-DI STI NCT PART 0 11,714 992.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 11,714 992.00 OTHER REI MBURSABLE COST CENTERS 0 Subtotal (see instructions) 0 303,988 00.00 Only Charges		0					
66. 00 06600 PHYSI CAL THERAPY 0 13, 029 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1, 035 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 9, 394 68. 00 6900 ELECTROCARDI OLOGY 0 2, 688 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5, 518 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1, 804 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 72, 190 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 72, 190 73. 00 074698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.98 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			
67. 00	The state of the s		-				
68. 00							
69. 00							
71. 00							
72. 00							
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 72, 190 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 0 0 0 0							
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 90. 01 09001 SENI OR CARE 0 0 0 91. 00 09100 EMERGENCY 0 75, 297 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART 0 11, 714 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 200. 00 Subtotal (see instructions) 0 303, 988 201. 00 Cless PBP Clinic Lab. Services-Program 0 Only Charges 0 0 0 Only Charges 0 Only Char							
OUTPATIENT SERVICE COST CENTERS O			•				
90. 00		<u> </u>					70.70
90. 01 09001 SENI OR CARE 0 0 0 0 0 0 0 0 0		0	0				90.00
91. 00		0	0				
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 11,714 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 200. 00 Subtotal (see instructions) 0 303,988 200. 00 201. 00 0nly Charges 0 0nly Charges		o	75, 297				
OTHER REIMBURSABLE COST CENTERS 95.00		o					
200.00 Subtotal (see instructions) 0 303,988 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00		<u>'</u>					
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges	95. 00 09500 AMBULANCE SERVICES	0					95. 00
Only Charges	200.00 Subtotal (see instructions)	0	303, 988				200. 00
	201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
202.00 Net Charges (line 200 - line 201) 0 303,988 202.00	Only Charges						
	202.00 Net Charges (line 200 - line 201)	0	303, 988				202. 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	From 01/01/2018	Date/Time Prepared:
			4/27/2020 11:05 am
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	4/27/2020 11: Cost	05 am_
	Cost Center Description	THE WITTE	nospi tui	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 768	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			3, 727	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 599	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	30	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember .	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	11	7. 00
0.00	reporting period	, daya) after December 2	l of the cost	0	0 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	i days) after beceiliber 3	i oi the cost	U	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 143	9. 00
40.00	newborn days)			20	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)	30	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (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
	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 o	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	arter becomber or or	1110 0031		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	137. 32	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	137. 32	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			6, 081, 214	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 or the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24.00	x line 18)	- 21 -6 +6++:		1 511	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporting	ng period (iine	1, 511	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27, 00	x line 20)			FO 0F0	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		50, 058 6, 031, 156	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11110 21 111110 20)		3, 33.1, 133	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	6, 031, 156	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 618. 23	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 849, 637	39. 00
40. 00	Medically necessary private room cost applicable to the Program	,		1 940 427	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	1, 849, 637	41.00

	<u> </u>	ARKVIEW WABASH F				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-1310	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 4/27/2020 11:	pared:
	Control Description	Tatal		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl		col . 2)	÷	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	J O	<u> </u>	<u>J</u>	00 0	<u> </u>	42.00
	INTENSIVE CARE UNIT						43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					879, 042	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructi	ons)		2, 728, 679	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	/ services (f	rom Wkst. D.	sum of Parts II	0	51.00
	and IV)	•	, (1				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-ph	vsician andet	hetist and	0	
33.00	medical education costs (line 49 minus line		ateu, non-pn	ysi ci aii ailest	netrst, and] 33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION]
	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (line 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period (endi ng 1996,	updated and c	ompounded by the	0.00	
	market basket		0	•			
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less tha	n expected costs			,		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			ő	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Dogor	hor 21 of th	o cost roport	ing pariod (Sac	40 E47	64. 00
64. 00	instructions) (title XVIII only)	ts till ought becei	ibei 31 01 tii	e cost report	riig perrou (see	48, 547	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line o	64 plus line	65)(title XVI	II only). For	48, 547	66.00
	CAH (see instructions)		•		•		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (ine 67 + lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
72. 00	Program routine service cost (line 9 x line		,	-/			72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II. column		74. 00 75. 00
	26, line 45)				, _5. a		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 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			1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatio	n (line /8 Mi	nus iine 79)		80.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (s)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	,	ıs)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th	•				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 128	87. 00
	* '		line 2)			1, 618. 23	1
	Observation bed cost (line 87 x line 88) (se					1, 825, 363	

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		Peri od:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018	Date/Time Pre 4/27/2020 11:0	
		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 O	COST					
90.00 Capital -related cost	801, 102	6, 081, 214	0. 13173	1, 825, 363	240, 462	90.00
91.00 Nursing School cost	0	6, 081, 214	0.00000	1, 825, 363	0	91.00
92.00 Allied health cost	0	6, 081, 214	0.000000	1, 825, 363	0	92.00
93.00 All other Medical Education	0	6, 081, 214	0.000000	1, 825, 363	0	93. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2018	Worksheet D-1
		To 12/31/2018	Date/Time Prepared: 4/27/2020 11:05 am
	Title XIX	Hospi tal	PPS

PART 1 ALL PROVIDER COMPONENTS PART 1 ALL PROVIDER COMPONENTS
PART 1 - ALL PROVIDER COMPONENTS
NAME ALL PROVIDER COMPONENTS
INPATEENT DAYS
Inpatient days (including private room days and saing-bed days, excluding newborn) 3,768 1.00 2.00 Inpatient days (including private room days, excluding saing-bed and newborn days) 3,777 2.00 2.0
Impatient days (including private room days, excluding swing-bed and newborn days) 1, you have only private room days (sectuding swing-bed and observation bed days) 1, you have only private room days (and not complete this line. 2, 599 4.00 5.00 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line. Private room days (excluding swing-bed and observation bed days) through December 31 of the cost swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (if calledary year, enter 0 on this line) reporting period reporting period reporting period reporting period (if calledary year, enter 0 on this line) reporting period report
do not complete this line. do not complete this line.
Semi-private room days (excluding swing-bed and observation bed days) 2,599 4,00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 o
reporting period 1.00 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) 1.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 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) 1.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 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) 1.00 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) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (including swing-bed days) 1.00 Medical varies of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Medical varies of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Medical varies of the cost reporting period (including private room days) 1.00 Medical of rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 x x line 1) 1.00 Medical of rate for swing-bed SNF services
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) 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) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 10 total inpatient days applicable to thite XVIII only (including private room days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 10 total inpatient days applicable to thite XVIII only (including private room days) Through December 31 of the cost reporting period (is calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter of the cost reporting period (if calendar year, enter 0 on this line) Alter o
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reporting period 8. 00 Total swing-bed Nr 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) 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 (see instructions) 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 NF type inpatient days applicable to titles V or XIX anly (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX anly (including private room days) 14. 00 Medically in excessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX anly) 16. 00 Nursery days (title V or XIX anly) 17. 00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18. 00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 18. 00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19. 00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19. 00 Medicaler rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 29. 00 Swing-bed
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reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.01 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (see instructions) 7.02 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 1.00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 1.00 SWING SED ADUSTNEMT 1.00 SWING SED SWING SED SWING SED SWING S
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655)
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 99. 00 Private room charges (excluding swing-bed charges) 90. 00 Semi-private room charges (excluding swing-bed charges) 91. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 91. 00 Average private room per diem charge (line 29 ÷ line 3) 91. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 91. 00 Average per diem private room cost differential (line 34 x line 31) 91. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 032, 655) 91. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 032, 655) 92. 00 Average per diem private room cost differential (line 3 x line 35) 92. 00 Average per diem private room cost differential (line 3 x line 35) 93. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 032, 655) 93. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 032, 655)
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00
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35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655) 37.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6,032,655 37.00
127 minus Line 24)
27 minus line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,618.64 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 43,703 39.00
39.00 Program general inpatient routine service cost (line 9 x line 38) 43,703 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 43,703 41.00

	Financial Systems P. ATION OF INPATIENT OPERATING COST	ARKVIEW WABASH H	OSPITAL, INC. Provider Co	N· 15-1310	In Lie	eu of Form CMS-2 Worksheet D-1	
OWI OTA	THE OF THE ATTENT OF ENATITIES COST		Trovider co	JN. 13-1310	From 01/01/2018 To 12/31/2018	3	
			T	WI W		4/27/2020 11:	
	Cost Center Description	Total		e XIX Average Per	Hospital Program Days	PPS Program Cost	
	oost center bescription	Inpatient Cost I			5	(col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	NURSERY (title V & XIX only)	240, 310	40	6, 007.	75 14	84, 109	42. (
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT					T	43. (
	CORONARY CARE UNIT						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 (Wk	st. D-3, col. 3,	line 200)			61, 056	48. (
	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructio	ns)		188, 868	49.
	PASS THROUGH COST ADJUSTMENTS	ationt routing c	orvioss (from	Wket D su	m of Dorte L and	10.445	F
0. 00	Pass through costs applicable to Program inp	attent routine s	ervices (iron	WKSt. D, Su	III OI PAILS I ANG	10, 445	50.
1. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	5, 739	51.
	and IV)	FO 1 513					
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non nhi	eician anac+	hatist and	16, 184 172, 684	1
3.00	medical education costs (line 49 minus line		ateu, non-pny	Si Ci ali allest	netist, and	172,004	33.
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
- 1	Program di scharges					0	
	Target amount per discharge					0.00	1
1	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	det amount (1	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)	ring cost and tar	get amount (1	1110 00 1111 1103	11110 00)	ő	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, u	pdated and c	ompounded by the	0.00	59
	market basket					0.00	1,0
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	1
1.00	which operating costs (line 53) are less that						01.
	amount (line 56), otherwise enter zero (see	instructions)			· ·		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	ti ons)			1 0	03.
	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See	0	64.
	instructions)(title XVIII only)					_	
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reportin	g period (See	0	65.
5. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	0	66.
	CAH (see instructions)		·		•		
7. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost r	eporting period	0	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	ortina period	0	68.
	(line 13 x line 20)				· · · · · · · · · · · · · · · · ·		
	Total title V or XIX swing-bed NF inpatient					0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				<u> </u>	T	70.
	Adjusted general inpatient routine service c)		71.
1	Program routine service cost (line 9 x line			,			72.
	Medically necessary private room cost applic			ne 35)			73.
	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,	orkshoot P	Dort II column		74. 75.
0. 00	26, line 45)	Toutine Service	COSTS (110III W	orksneet b,	Part II, Corumni		/5.
6. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
1	Program capital -related costs (line 9 x line						77.
1	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	ovi der rocerd	e)			78. 79.
	Total Program routine service costs for comp				nus line 79)		80
	Inpatient routine service cost per diem limi				,		81
1	Inpatient routine service cost limitation (I						82
1	Reasonable inpatient routine service costs ()				83.
1	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84.
1	Total Program inpatient operating costs (sum	•					86.
ļ	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
7.00	Total observation bed days (see instructions	•				1, 128	1
	Adjusted general inpatient routine cost per	diam (lina 27 ·	line '''			1, 618. 64	

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		Peri od:	Worksheet D-1	
				From 01/01/2018 Fo 12/31/2018	Date/Time Pre 4/27/2020 11:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH C	OST					
90.00 Capital -related cost	801, 102	6, 081, 214	0. 13173	1, 825, 826	240, 523	90.00
91.00 Nursing School cost	0	6, 081, 214	0.00000	1, 825, 826	0	91.00
92.00 Allied health cost	0	6, 081, 214	0.000000	1, 825, 826	0	92.00
93.00 All other Medical Education	0	6, 081, 214	0.000000	1, 825, 826	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Hoal th	Financial Systems PARKVIEW WABASH HO	SDITAL INC		In Lie	of Form CMS	2552 10
Title XVIII				CN: 15-1310			
Title XVIII Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Inpatient Program Pro	1 141 741 1	ENT ANOTEENT SERVICE GOOT AT ORTHORIMENT	I TOVI GET 0	014. 10 1010	From 01/01/2018		
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00					To 12/31/2018		
Nation of Cost Inpatient Inpatient To Charges Program Charges Program Charges Program Charges Program Charges Program Charges Program Charges			Ti +Lc	VVIII	Hospi tal		05 am
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 30.00 ADULTS & PEDIATRIC S 1.989,009 43.00 43		Cost Center Description	11116				
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		oost center bescription					
INPATI ENT ROUTINE SERVICE COST CENTERS 1, 989, 009 30. 00							
NPATI_ENT_ROUTI_NE_SERVI_CE_COST_CENTERS 1,989,009 30.00 43.00 0300 ADULTS & PEDI_ATRICS 1,989,009 343.00 43					3.1		
30. 00 3000 3000 ADULTS & PEDIATRICS 1,989,009 30. 00 43. 00 A3. 00				1.00	2. 00	3. 00	
43. 00							
ANCILLARY SERVICE COST CENTERS					1, 989, 009		
50. 00 05000 DERATING ROOM 0.324206 175, 248 56, 816 50. 00 51. 00 51. 00 5100 RECOVERY ROOM 4.121860 0.000000 0 0.52. 00 52. 00 53. 00 05200 DELIVERY ROOM & LABOR ROOM 4.121860 0 0.52. 00 53. 00 05300 ANESTHESI OLOGY 0.006822 17, 203 117 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.127784 405, 325 51, 794 54. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0.56. 00 0.000000 0 0.000000 0 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.00000000	43.00						43. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0.000000 0.000000 0.0000000 0.00000000				1		1	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 4. 121860 0 0 52. 00							
53.00 05300 ANESTHESI OLOGY 0.006822 17, 203 117 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.127784 405, 325 51, 794 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 56.00 60.00 06000 LABORATORY 0.173373 568, 914 98, 634 60.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 63.00 64.00 06600 PHYSI CAL THERAPY 0.565629 101, 664 57, 504 45, 942 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.750644 61, 204 45, 942 67.00 68.00 06800 SPEECH PATHOLOGY 1.316559 13, 455 17, 714 68.00 69.00 06900 ELECTROCARDI OLOGY 0.304898 601, 078 183, 267 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.328695 105, 006 34, 515 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.379283 22, 028 6, 152 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.307252 1, 019, 479 313, 237 73.00 76.98 07698 HYPERBARI C OXYGEN THERAPY 0.220643 0 0 76.98 UTPATI ENT SERVI CE COST CENTERS 0.864712 0 0 90.01 90.01 09001 SENI OR CARE 0.864712 0 0 90.01 91.00 09200 DSSERVATI ON BEDS (NON-DI STI NCT PART 0.966150 0 0 90.00 92.00 09500 AMBULANCE SERVI CES 0.95000 0.9500 AMBULANCE SERVI CES 0.95000 90.00 0010 Less PBP Cli ni c Laboratory Servi ces-Program only charges (line 61) 0 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 20				1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127784 405, 325 51, 794 54. 00 56. 00 05600 RADI OLSGY-DI AGNOSTI C 0. 000000 0 0 56. 00 0. 000000 0 0 56. 00 0. 000000 0 0 56. 00 0. 000000 0 0 0 56. 00 0. 000000 0 0 0 0. 000000 0							
56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 56. 00							
60. 00							
63. 00				1		-	
66. 00							
67. 00 06700 0CCUPATI ONAL THERAPY 0.750644 61, 204 45, 942 67. 00 68. 00 06800 SPEECH PATHOLOGY 1.316559 13, 455 17, 714 68. 00 06900 ELECTROCARDI OLOGY 0.304898 601, 078 183, 267 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.328695 105, 006 34, 515 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.279283 22, 028 6, 152 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.307252 1, 019, 479 313, 237 73. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.220643 0 0 0 76. 98 0000 00000 CLI NI C 0.0000 00000 CLI NI C 0.00000 0.00000 0.0000000000000						_	
68. 00 06800 SPEECH PATHOLOGY 1. 316559 13, 455 17, 714 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 304898 601, 078 183, 267 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 328695 105, 006 34, 515 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 279283 22, 028 6, 152 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 307252 1, 019, 479 313, 237 73. 00 76. 98 0000							
69. 00 06900 CHECTROCARDIOLOGY 0.304898 601, 078 183, 267 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.328695 105, 006 34, 515 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.279283 22, 028 6, 152 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.307252 1, 019, 479 313, 237 73. 00 76. 98 HYPERBARI C OXYGEN THERAPY 0.20643 0 0 0 0 0 0 0 0 0				1	· ·		
71. 00				1	· ·		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 279283 22, 028 6, 152 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0. 307252 1, 019, 479 313, 237 73. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 220643 0 0 76. 98 0 0 0 0 0 0 0 0 0							
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.307252 1,019,479 313,237 73. 00 76. 98 0.220643 0 0 0 76. 98 0.220643 0 0 0 0 0 0 0 0 0				1	· ·		
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0. 220643 0 0 76. 98							
OUTPATIENT SERVICE COST CENTERS OUTP							
90. 00 09000 CLINIC 0. 220431 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90	70.70			0.2200			70.70
90. 01 09001 SENI OR CARE 0. 864712 0 0 90. 01 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 966150 0. 966150 0. 966150 0. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 966150	90. 00			0. 2204	31 0	0	90.00
91. 00 09100 EMERGENCY 0. 271000 49, 263 13, 350 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 966150 0. 966150 0. 966150 0. 966150 0. 92. 00 000							
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.966150 0 0 92. 00	91.00	09100 EMERGENCY				13, 350	91.00
OTHER REIMBURSABLE COST CENTERS 95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 9661			92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 3,139,867 879,042 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00		OTHER REIMBURSABLE COST CENTERS					
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
	200.00				3, 139, 867	879, 042	200. 00
202.00 Net charges (line 200 minus line 201) 3,139,867 202.00			s (line 61)		0		
	202.00	Net charges (line 200 minus line 201)			3, 139, 867		202. 00

	SH HOSPITAL, INC.			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2018	Worksheet D-3	
	Component	CCN: 15-Z310	To 12/31/2018	Date/Time Pre 4/27/2020 11:	
	Titl∈	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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			43, 133		30.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					1
50.00 05000 OPERATING ROOM		0. 32420		0	
51.00 05100 RECOVERY ROOM		0.00000		0	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		4. 12186		0	
53. 00 05300 ANESTHESI OLOGY		0. 00682		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12778		0	
56. 00 05600 RADI 0I SOTOPE		0. 00000		0	
60. 00 06000 LABORATORY		0. 17337		1, 317	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 56562		10, 074	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 75064		10, 434	1
68. 00 06800 SPEECH PATHOLOGY		1. 31655		1, 245	
69. 00 06900 ELECTROCARDI OLOGY		0. 30489		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 32869		3, 339	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 27928		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 30725		958	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 22064	13 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLI NI C		0. 22043		0	
90. 01 09001 SENI OR CARE		0. 86471		0	
91. 00 09100 EMERGENCY		0. 27100		0	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 96615	0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVI CES	>				95. 00
Total (sum of lines 50 through 94 and 96 through 9			53, 531	27, 367	
201.00 Less PBP Clinic Laboratory Services-Program only c	narges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		I	53, 531		202. 00

	Financial Systems	PARKVI EW WABASH HOS				eu of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1310	Period: From 01/01/2018	Worksheet D-3	
					To 12/31/2018		
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1. 00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1		1	
30.00	03000 ADULTS & PEDI ATRI CS				57, 489		30.00
43. 00	04300 NURSERY				4, 820		43.00
F0 00	ANCILLARY SERVICE COST CENTERS			0.0040	0.1	44.455	
	05000 OPERATI NG ROOM			0. 3242	·		
	05100 RECOVERY ROOM			0.0000		1	51.00
	05200 DELIVERY ROOM & LABOR ROOM			4. 1218		0	52.00
	05300 ANESTHESI OLOGY			0.0068			
	05400 RADI OLOGY-DI AGNOSTI C			0. 1277			54. 00 56. 00
	05600 RADI OI SOTOPE 06000 LABORATORY			0. 0000 0. 1733		0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.			0.1733		7, 362 0	63.00
	06600 PHYSI CAL THERAPY			0. 5656		-	
	06700 OCCUPATIONAL THERAPY			0. 3636			67.00
	06800 SPEECH PATHOLOGY			1. 3165			68.0
	06900 ELECTROCARDI OLOGY			0. 3048		_	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 3286			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 3200			
	07300 DRUGS CHARGED TO PATIENTS			0. 3072			
	07698 HYPERBARI C OXYGEN THERAPY			0. 2206			76. 98
. 5. 75	OUTPATIENT SERVICE COST CENTERS			3. 2200	.5, 0		1 , 0. /
90. 00	09000 CLINI C			0. 2204	31 0	0	90.00
	09001 SENI OR CARE			0. 8647		0	90.0
	09100 EMERGENCY			0. 2710		_	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 9661	·		92.00
00	OTHER REIMBURSABLE COST CENTERS			0.7001			1
95 00	09500 AMBULANCE SERVICES						95 0

95.00

202. 00

61, 056 200. 00 201. 00

243, 838 0 243, 838

95.00 O9500 AMBULANCE SERVICES
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)
202.00 Net charges (line 200 minus line 201)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-1	0
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	Peri od: From 01/01/2018 Part B To 12/31/2018 Date/Time Prepared:	

				4/27/2020 11:	05 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8, 015, 725	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		0	2. 00
3.00	OPPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	ations)		0 000	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	ctrons)		0. 000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	9. 00
10. 00	Organ acquisitions	V, COI. 13, 1111C 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 015, 725	
	COMPUTATION OF LESSER OF COST OR CHARGES			27 0 . 27 . 22	
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions)	vifling 10 avegade lin	0 11) (600	0	18. 00 19. 00
19.00	Excess of customary charges over reasonable cost (complete onlinstructions)	y IT TITLE TO exceeds ITT	le II) (See	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds lin	e 18) (see	0	20. 00
20.00	instructions)	y II IIIIc II cacceds III	(300	O	20.00
21. 00	Lesser of cost or charges (see instructions)			8, 095, 882	21. 00
22. 00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		68, 033	
26. 00	Deductibles and Coinsurance amounts relating to amount on line			5, 170, 223	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	2, 857, 626	27. 00
00.00	instructions)	50)			00.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 2, 857, 626	29. 00 30. 00
31. 00	Primary payer payments			2, 657, 626	31.00
32. 00	Subtotal (line 30 minus line 31)			2, 857, 626	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CFS)		2,037,020	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			958, 699	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			623, 154	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		914, 129	36.00
37. 00	Subtotal (see instructions)			3, 480, 780	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruct	ions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			2 400 700	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 480, 780 69, 616	
40. 01	Demonstration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			09, 010	40. 01
41. 00	Interim payments			2, 615, 102	
42. 00	Tentative settlement (for contractors use only)			0	42. 00
43. 00	Balance due provider/program (see instructions)			796, 062	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, c	hapter 1,	0	
	§115. 2		·		
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
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	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		I	U	94. 00

Health Financial Systems PARKVII ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1310

					4/27/2020 11:0	05 am
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt 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		2, 604, 93	7	2, 556, 402	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)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	04/11/2010	40.50	0 04/11/2010	F0.700	2 01
3. 01	ADJUSTMENTS TO PROVIDER	04/11/2018	40, 500		58, 700 0	3. 01
3. 02		08/30/2018	64, 70	0		3. 02 3. 03
3. 03 3. 04				0		3.03
3. 04				0		3.04
3.05	Provider to Program			<u>U</u>	U	3.05
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADJUSTIMENTS TO TROURAIM			0		3. 51
3. 52				0		3. 52
3. 53				Ö	0	3. 53
3. 54				Ö	l ő	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		105, 200	-	58, 700	3. 99
	3. 50-3. 98)		,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 710, 13 ⁻	7	2, 615, 102	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider		Г			F 01
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01 5. 02
5. 02 5. 03				0		5.02
5.03	Provider to Program		'	<u> </u>	U	5.03
5. 50	TENTATI VE TO PROGRAM			0	1 0	5. 50
5. 51	TERRITIVE TO TROOKIN			0		5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	l ő	5. 99
	5. 50-5. 98)					, ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVI DER			0	796, 062	6. 01
6.02	SETTLEMENT TO PROGRAM		358, 29	5	0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 351, 84		3, 411, 164	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2.00	8. 00

 Heal th
 Financial
 Systems
 PARKVI

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED

		Component	JCN. 13-Z310 1	0 12/31/2010	4/27/2020 11:0	
		Title	XVIII S	wing Beds - SNF		
		Inpatien	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		113, 311		0	1. 00
2.00	Interim payments payable on individual bills, either		C		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)					
0.01	Program to Provider					0.04
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3. 03
3.04			C		0	3. 04
3. 05			C)	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM	I	1 0	,	0	3.50
3. 50	ADJUSTMENTS TO PROGRAM					3. 50
3. 51						3. 51
3. 52						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 77	3. 50-3. 98)			,	U	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		113, 311		0	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1.0,01.			
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	•	•	•		
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02			C		0	5. 02
5.03			C)	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
,	5. 50-5. 98)					,
6.00	Determined net settlement amount (balance due) based on					6. 00
/ O1	the cost report. (1)				0	/ 01
6. 01	SETTLEMENT TO PROVIDER		1			6. 01
6. 02	SETTLEMENT TO PROGRAM		38, 171		0	6. 02
7.00	Total Medicare program liability (see instructions)		75, 140	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor	,		1.00	2.00	8. 00
5. 50	1	I .		1	1	, 5.50

Heal th	Financial Systems PARKVIEW WABASH	I HOSPITAL, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1310	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Pre 4/27/2020 11:	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	I ON			
1.00	Total hospital discharges as defined in AARA §4102 from Wk	kst. S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1	I, 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	I, 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 cline 168	of certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions	s)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00					10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	31.00 Other Augustinent (specify)				

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 HO	SPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provider CCN: 15-1310	Peri od: From 01/01/2018	Worksheet E-2
		Component CCN: 15-Z310		

				4/27/2020 11:	05 am
		Title XVIII S	wing Beds - SNF	Cost	
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPDED OFFINA OF		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		40.022	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		49, 032	U	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	27, 641	0	3.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst		27,041	O	3.00
4.00	Per diem cost for interns and residents not in approved teachir			0.00	4. 00
	instructions)	5 F - 5 - C			
5.00	Program days		30	0	5. 00
6.00	Interns and residents not in approved teaching program (see ins			0	6. 00
7. 00	Utilization review - physician compensation - SNF optional meth	nod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		76, 673	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)	able to abusicion	76, 673	0	10. 00 11. 00
11. 00	Deductibles billed to program patients (exclude amounts applical professional services)	ibi e to physician	٩	0	11.00
12. 00	Subtotal (line 10 minus line 11)		76, 673	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	0	0	13. 00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	1)	76, 673	0	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra	ation) payment	0		16. 55
16. 99	adjustment (see instructions)			0	16. 99
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	17. 00
	Adjusted reimbursable bad debts (see instructions)			0	17. 00
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	o	0	18. 00
	Total (see instructions)	, , , , , , , , , , , , , , , , , , , ,	76, 673	0	19. 00
19. 01	Sequestration adjustment (see instructions)		1, 533	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		O	0	19. 02
20.00	Interim payments		113, 311	0	20. 00
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, ar		-38, 171	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	0	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra</pre>	ution) Adjustment			
200 00	Is this the first year of the current 5-year demonstration peri				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	od dilder the 21st			200.00
	Cost Reimbursement		· ·		
201.00	Medicare swing-bed SNF inpatient routine service costs (from We	st. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, line			202. 00
202.00	200 (title XVIII swing-bed SNF))				202 00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the current	5-year demonst		204.00
	period)	Trist year or the current	5-year demonstr	i ati on	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times)	nes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	Program reimbursement under the §410A Demonstration (see instru	•			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines 1			208. 00
000 5-	and 3)				000 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	ions)			209. 00
∠10.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				210. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	09 nlus line 210) (see			215. 00
213.00	instructions)	,, p. 43 11110 210) (300			215.00
					'

Health Financial Systems	PARKVIEW WABASH HOSE	PITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1310	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 4/27/2020 11:05 am
		Ti +1 o V/// / /	Hospi tal	Coct

			10 12/31/2016	4/27/2020 11:0	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 728, 679	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ns)		0	2. 00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			2, 728, 679	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, 755, 966	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
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 page 1	ayment for services on a	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for	payment for services of	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14. 00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	y if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only	y if line 6 exceeds line	e 14) (see	0	16. 00
47.00	instructions)				47.00
17. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1: 40)		0	40.00
18. 00 19. 00	Direct graduate medical education payments (from Worksheet E-4,	, Tine 49)		0 2, 755, 966	18. 00 19. 00
20. 00	Cost of covered services (sum of lines 6, 17 and 18)			2, 755, 966 369, 603	20.00
	Deductibles (exclude professional component)				
21. 00 22. 00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			0 2, 386, 363	21. 00 22. 00
23. 00	Coi nsurance			2, 380, 303	23. 00
24. 00				2, 386, 363	
25. 00	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional service	as) (ass imptrustions)			25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)	es) (see mstructions)		20, 732 13, 476	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		16, 712	
28. 00	· ·	uctions)		2, 399, 839	
29. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 399, 639	29. 00
29. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	29. 50
29. 50	Pioneer ACO demonstration payment adjustment (see instructions))		0	29. 50
29. 99 30. 00	Demonstration payment adjustment amount before sequestration			2, 399, 839	29. 99 30. 00
30. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 399, 639 47, 997	
30. 01	Demonstration payment adjustment amount after sequestration			47, 997	30. 01
31.00	Interim payments Tentative settlement (for contractor use only)			2, 710, 137 0	31. 00 32. 00
32. 00 33. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 30.02,	31 and 33)			
34. 00	Protested amounts (nonallowable cost report items) in accordance		chantor 1	-358, 295 0	34. 00
34.00	§115. 2	CE WITH CIND PUD. 10-2, (chapter 1,	ا	34.00
	13.10.2		ı		

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 F

A	oni y)				12/01/2010	4/27/2020 11:	05 am
Display September Septem			General Fund		Endowment Fund	Plant Fund	
Cash on hand in banks			1.00		3. 00	4.00	
1.00 Compared y investments			I			_	
3.00 Notes receivable 0 0 0 0 3.00 5.00 Other receivable 18,393,748 0 <td< td=""><td></td><td></td><td>870, 280</td><td></td><td>0</td><td>•</td><td></td></td<>			870, 280		0	•	
4.00 Accounts receivable 4.00		'	0		-		
October Tread valid Color Colo			18 393 748	1	1		
All lowances for uncal lectible notes and accounts receivable -10, 694, 451 0 0 0 0 0 0 0 0 0				1	o o		
1.00 Prepaid Expenses 56, 776 0 0 0 0 0 0 0 0 0	6.00	Allowances for uncollectible notes and accounts receivable			0	0	6. 00
9.00 Other current assets			778, 933	(0		
10.00 Due from other funds			56, 776		-	l .	
11.00 Charles Charle			40 404 040	1	,		
FIXED ASSETS					-	•	1
12.00 Land Inprovements	11.00		-31,410,700	/	<u> </u>	0	11.00
13.00 Land improvements	12.00		1, 208, 757	' (0	0	12. 00
15.00 Bail dings				1	0		
16.00 Accumulated depreciation -21, 467, 125 0 0 0 16.00	14.00	Accumulated depreciation	-39, 567	' (0	0	14. 00
17.00 Leasehol d Improvements					-		
18.00 Accumulated depreciation 0 0 0 0 18.00		•	-21, 467, 125	1	-	•	
19.00 Fixed equipment		· ·	0	1	-		
20.00 Accumulated depreciation -199, 401 0 0 0 20.00		•	1 050 604	1	1		
21.00 Automobil les and trucks 23, 431 0 0 0 21.00		1		1		l	
22.00 Accumulated depreciation -23, 430 0 0 0 22.00		•		1		l	
24.00 Accumul ated depreciation				1	-		
25.00 M Inor equipment depreciable 0 0 0 0 0 25.00 27.00 HT designated Assets 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00	Maj or movable equipment	11, 931, 807	' (0	0	23. 00
26.00 Accumul ated depreciation 0 0 0 0 26.00 27.00 HT designated Assets 0 0 0 0 0 27.00 28.00 Accumul ated depreciation 0 0 0 0 27.00 28.00 Accumul ated depreciation 0 0 0 0 28.00 30.00 Total fixed assets (sum of lines 12-29) 43,270,757 0 0 0 30.00 30.00 Total fixed assets (sum of lines 12-29) 43,270,757 0 0 0 30.00 31.00 Investments 318,100 0 0 0 31.00 32.00 Due from owners/officers 0 0 0 0 32.00 32.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets 0 0 0 0 33.00 36.00 Total other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Total assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 35.00 36.00 Other assets (sum of lines 31-34) 640,865 0 0 0 36.00 37.00 Other assets (sum of lines 31-34) 640,865 0 0 0 36.00 38.00 Salaries, wages, and fees payable 1,835,824 0 0 0 0 37.00 39.00 Payroll taxes payable 583,624 0 0 0 0 0 39.00 Payroll taxes payable 0 0 0 0 0 0 39.00 Other and lines			-3, 135, 330) (0		
27.00 HIT designated Assets 0 0 0 0 27.00			0	1	1		
28.00 Accumula*Ted depreciation 0 0 0 0 0 0 28.00		•	0		0		
29.00 Minor equipment-nondepreciable 0 0 0 0 29.00			0		0	•	
Total Fixed assets (sum of lines 12-29)		•		1	-	•	
OTHER ASSETS Investments 318,100 0 0 0 31,00 32,00 32,00 32,00 32,00 0 0 0 0 0 0 32,00 33,00 0 0 0 0 0 0 0 32,00 33,00 0 0 0 0 0 0 0 33,00 0 0 0 0 0 0 33,00 0 0 0 0 0 0 33,00 0 0 0 0 0 0 0 0 0			43 270 757	1	-		
31.00 Investments	00.00		10, 270, 707		<u>, </u>		30.00
33. 00 Due from owners/officers 0 0 0 0 33. 00	31.00		318, 100) (0	0	31.00
34. 00 Other assets 30. 00 Other assets 30. 00 Total assets (sum of lines 31-34) 35. 00 Total assets (sum of lines 31-34) 35. 00 Total assets (sum of lines 31-34) 36. 00 Total assets (sum of lines 31-34) 37. 00 Accounts payable 38. 00 Salaries, wages, and fees payable 39. 00 Payroll taxes payable 39. 00 P	32.00	Deposits on Leases	0) (0	0	32. 00
35.00			0	1	0	1	1
36. 00 Total assets (sum of lines 11, 30, and 35) 12,500,862 0 0 0 36. 00					1	l	1
Output Company Compa		1	· ·	•	·	l e	
37.00 Accounts payable 1,835,824 0 0 0 0 37.00 38.00 Salaries, wages, and fees payable 583,624 0 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 0 0 0	36.00		12, 500, 862		0		36.00
38.00 Salaries, wages, and fees payable 583,624 0 0 0 0 38.00 39.00 Payrol I taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 0 0 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 44.00 45.00 Other current liabilities 2,048,751 0 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 4,468,199 0 0 0 0 0 47.00 46.00 Mortgage payable 0 0 0 0 0 0 47.00 47.00 Notes payable 0 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 47.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 24, 139,016 0 0 0 0 49.00 51.00 Total liabilities (sum of lines 45 and 50) 28,607,215 0 0 0 55.00 52.00 General fund balance 5.50 Coperated - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance - unrestricted 55.00 Plant fund balance - invested in plant 7.50 Coperated - endowment fund balance - unrestricted 55.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 7.50 Coperated - endowment fund balance (sum of lines 51 and 12,500,862 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37. 00		1, 835, 824	. (0	0	37. 00
39.00 Payroll taxes payable 0 0 0 0 39.00				1	-		
41.00 Deferred income 0 0 0 0 41.00	39. 00	Payrol I taxes payable	0	1	0	0	39. 00
42. 00	40.00	Notes and Loans payable (short term)	0) (0		
43.00 Due to other funds 44.00 Other current liabilities 45.00 Other current liabilities (sum of lines 37 thru 44) 45.00 Dong TERM LIABILITIES 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities (sum of lines 46 thru 49) 49.00 Other long term liabilities (sum of lines 46 thru 49) 49.00 Other long term liabilities (sum of lines 46 thru 49) 49.00 Other long term liabilities 40.00 Other long term liabilities 41.00 Other long term liabilities 424, 139, 016 42, 139, 016 424, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 42, 139, 016 43.00 45.00 46.00 47.00 48.00 47.00 48.00 47.00 48.00 47.00 48.00 47.00 48.00 49			0) (0	0	
44. 00 Other current liabilities		, ,	0				
45.00			2 049 751		0	l	
LONG TERM LIABILITIES			,		1		
46.00 Mortgage payable 0 0 0 0 0 0 0 0 46.00 47.00 Notes payable 0 0 0 0 0 0 0 0 0 0 0 47.00 48.00 Unsecured loans 0 0 0 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 24,139,016 0 0 0 0 50.00 51.00 Total long term liabilities (sum of lines 45 and 50) 28,607,215 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 59.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance 0 55.00 Plant fund balance - reserve for plant improvement, replacement, and expansion Total liabilities and fund balances (sum of lines 51 and 12,500,862 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00		1, 100, 177		<u>, </u>		10.00
48.00 Unsecured Loans 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 24, 139, 016 0 0 0 0 50.00 51.00 Total Liabilities (sum of Lines 46 thru 49) 24, 139, 016 0 0 0 50.00 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 12, 500, 862 0 0 0 0 60.00	46. 00		0) (0	0	46. 00
49.00 Other long term liabilities 24, 139, 016 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 24, 139, 016 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 28, 607, 215 0 0 0 51.00 52.00 General fund bal ance -16, 106, 353 0 52.00 52.00 53.00 Specific purpose fund 0 53.00 53.00 53.00 54.00 55.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 57.00	47.00	Notes payable	0) (0	0	47. 00
50.00 Total long term liabilities (sum of lines 46 thru 49)			0		0	•	
51.00 Total liabilities (sum of lines 45 and 50) 28,607,215 0 0 0 51.00					-	l	
CAPITAL ACCOUNTS 52. 00 General fund balance -16, 106, 353 52. 00 53. 00 Specific purpose fund 0 53. 00 54. 00 Donor created - endowment fund balance - restricted 0 54. 00 55. 00 Donor created - endowment fund balance - unrestricted 0 55. 00 56. 00 Governing body created - endowment fund balance 0 56. 00 57. 00 Plant fund balance - invested in plant 0 57. 00 58. 00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58. 00 59. 00 Total fund balances (sum of lines 52 thru 58) -16, 106, 353 0 0 0 59. 00 60. 00 Total liabilities and fund balances (sum of lines 51 and 12, 500, 862 0 0 0 60. 00		,					
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 53.00 53.00 54.00 55.00 56.00 57.00 58.00 59.00 59.00 59.00 59.00 59.00 60.00	51.00	CAPI TAL ACCOUNTS			JI O	<u> </u>	51.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54.00 55.			-16, 106, 353				52.00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion Flant fund balances (sum of lines 52 thru 58) Total fund balances (sum of lines 51 and Flant fund balances (sum of lines 51 and sum of lines 51 and sum of lines 51 and sum of lines					_		53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and 60.00 Total liabilities are fund balances (sum of lines 51 and succession					0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 12,500,862 0 57.00 58.00 0 0 59.00 0 0 60.00					0		1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) -16,106,353 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 12,500,862 0 0 60.00				1		_	
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 12,500,862 0 0 0 60.00		· ·		1			
59.00 Total fund balances (sum of lines 52 thru 58) -16, 106, 353 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and liabilities and fund balances) 12,500,862 0 0 0 60.00							
		Total fund balances (sum of lines 52 thru 58)			0		1
[59]	60.00		12, 500, 862	! (0	0	60.00
		(49)	I	I		I	I

| Period: | Worksheet G-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1310

					То	12/31/2018	Date/Time Prep 4/27/2020 11:0	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		-7, 903, 445			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8, 792, 844	•		_		2. 00
3.00	Total (sum of line 1 and line 2)		-16, 696, 289			0		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00		0			0		0	5. 00
6. 00 7. 00		0			0		0	6. 00 7. 00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0		U	o	o l	10.00
11. 00	Subtotal (line 3 plus line 10)		-16, 696, 289			0		11. 00
12. 00	Deductions (debit adjustments) (specify)		- 10, 070, 207		0	ď	0	12. 00
13. 00	beddetrons (debrt day dstillerits) (specify)				0		ő	13. 00
14. 00					0		ő	14. 00
15. 00					0		0	15. 00
16. 00		l ol			0		o	16. 00
17. 00		l ol			0		o	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			o		18. 00
19.00	Fund balance at end of period per balance		-16, 696, 289			o		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
			7.00	0.00				
4 00		6.00	7. 00	8. 00				4.00
1.00	Fund balances at beginning of period	0			0			1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	٩	0		U			4. 00
5.00	Additions (credit adjustments) (specify)		0					5. 00
6.00			0					6. 00
7. 00			0					7. 00
8. 00			0					8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)		ŭ		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	l ol			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00	, , , , , , , , , , , , , , , , , , , ,		0					13.00
14.00			0					14.00
15.00			0					15.00
16.00			0					16.00
17.00			0					17.00
18. 00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance	0			0			19.00
	sheet (line 11 minus line 18)							

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

			10 12/31/2018	Date/lime Pre 4/27/2020 11:0		
	Cost Center Description	Inpatient	Outpati ent	Total		
	•	1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	4, 448, 2	00	4, 448, 200	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	24, 9	40	24, 940	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)	4, 473, 1	40	4, 473, 140	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	SURGICAL INTENSIVE CARE UNIT				14.00	
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00	
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	0	0	16. 00	
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 473, 1	40	4, 473, 140	17. 00	
18. 00	Ancillary services	10, 271, 4		10, 271, 498	18. 00	
19. 00	Outpati ent servi ces		0 107, 573, 801	107, 573, 801	19. 00	
20.00	RURAL HEALTH CLINIC		0	0	20.00	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00	
22. 00	HOME HEALTH AGENCY		0	0	22. 00	
23.00	AMBULANCE SERVICES		0	0	23. 00	
24.00	CMHC				24. 00	
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00	
26.00	HOSPI CE		0	0	26. 00	
27. 00	FUTURE RHCS (PHYS CLINICS)		0 4, 923, 852	4, 923, 852	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	to Wkst. 14,744,6	38 112, 497, 653	127, 242, 291	28. 00	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		51, 391, 233		29. 00	
30.00	BAD DEBT	3, 874, 7			30.00	
31. 00	HOME OFFICE INTEREST EXPENSE	589, 9			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)		4, 464, 672		36. 00	
37.00	DEDUCT (SPECIFY)		0		37. 00	
38. 00			0		38. 00	
39. 00			0		39. 00	
40.00			0		40.00	
41.00			0		41. 00	
42.00	Total deductions (sum of lines 37-41)		0		42.00	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	55, 855, 905		43.00	
	to Wkst. G-3, line 4)	ĺ				

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-					2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1310 Period:			Worksheet G-3	
			From 01/01/2018	5	
			To 12/31/2018	Date/Time Prep 4/27/2020 11:0	
				4/2//2020 11.	US AIII
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		127, 242, 291	1.00
2. 00	Less contractual allowances and discounts on patients' accounts			81, 183, 907	2. 00
3. 00	Net patient revenues (line 1 minus line 2)			46, 058, 384	
4.00				55, 855, 905	
5. 00	Net income from service to patients (line 3 minus line 4)	,		-9, 797, 521	
	OTHER I NCOME			.,,,,,,,	
6.00	Contributions, donations, bequests, etc			10, 352	6. 00
7. 00	Income from investments			111, 353	
8. 00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			139, 079	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			214, 163	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other the	nan patients		298, 686	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			5, 995	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			181, 307	22. 00
23.00	Governmental appropriations			0	23. 00
24. 00	GAIN ON DISPOSAL OF ASSETS			1, 091	24. 00
24. 01	COUNTY REIMBURSEMENT AMBULANCE SVC			32, 904	24. 01
24. 02	MI SC			1, 181	24. 02
24 02	4 02 MISC EDOM DUVS DEFICES (FITTIDE DUCS)			0 566	24 02

8, 566

0 28.00

-8, 792, 844 29. 00

1, 004, 677

-8, 792, 844 0

24. 03

25.00

26. 00 27. 00

24.03 MISC FROM PHYS OFFICES (FUTURE RHCS)

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

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