## PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

Contractor use only

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 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 01/01/2016 and ending 12/31/2016 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.

> (Si aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-153, 714	-900, 607	20, 902	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	7, 088	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-146, 626	-900, 607	20, 902	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 11:41 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 710 NORTH EAST STREET P0 Box: 548 1.00 1.00 Zip Code: 46992-0548 County: WABASH 2.00 City: WABASH State: IN 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N) Туре Certi fi ed Number Number XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PARKVI EW WABASH 151310 99915 12/17/2001 N 0 3.00 HOSPITAL, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF PARKVIEW WARASH 157310 99915 N 12/17/2001 Ν 0 7 00 7.00 HOSPITAL SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA WABASH-MIAMI HOME 157061 99915 01/01/1979 Ν Ρ Ν 12.00 HEALTH 13.00 Separately Certified ASC 13.00 14.00 14.00 Hospi tal -Based Hospi ce WARASH-MIAMI HOSPICE 99915 151545 01/01/1996 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22. 02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2 or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 2 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" "N" for no for ves or Other In-State In-State Out-of Out-of Medicai d Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state o 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

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)

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)

Health Financial Systems PARKVIEW WABASH I				_ieu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		eriod: rom 01/01/20 o 12/31/20		
			V	5/30/2017 11 XI X	
			1. 00	2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appropriate Rural Providers	olicable column	n.	0.00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 of this facility qualifies as a CAH, has it elected the all-		nod of payment	Y N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost 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. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1. 00	0ccupational 2.00	Speech 3.00	Respiratory 4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for	N	110. 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	If column 2 i	is "E", enter i	n column	N O	115. 00
psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	rs) based on th	ne definition i	n CMS		
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur	-			N N	116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy i	s	0	118. 00
crafiii-illade. Effer 2 ff the politcy is occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 58, 196	2. 00	3.00	2 118. 01
The office of another of many detries promitted and part ressess.		1 00, 170			
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.	center other dule listing co	than the ost centers	1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in			N	N	119. 00 120. 00
"N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.					
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121. 00
122.00 Does the cost report contain state health or similar taxes?  for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N		122. 00
Transplant Center Information					<b></b>
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	,		N		125. 00
126.00  f this is a Medicare certified kidney transplant center, er  in column 1 and termination date, if applicable, in column 2	2.				126. 00
127.00  f this is a Medicare certified heart transplant center, entire in column 1 and termination date, if applicable, in column 1	2.				127. 00
128.00  f this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 1	2.				128. 00
129.00 olf this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.  130.00 olf this is a Medicare certified pancreas transplant center,					129. 00
date in column 1 and termination date, if applicable, in col	umn 2.				
131.00 of this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00 of this is a Medicare certified islet transplant center, en	umn 2.				131. 00
in column 1 and termination date, if applicable, in column 2		. Sation date			1.02.00

Health Financial Systems	PARKVIEW WABASH H	OSPITAL, INC.			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provider CO	CN: 15-1310	Peri od:		Worksheet S-	
					1/01/2016 2/31/2016		onarod:
				10 12	2/31/2010	5/30/2017 11	
122 COLF this is a Madisons contified at	har transplant contar ant	on the contifi	ication dat		1. 00	2. 00	122.00
133.00 If this is a Medicare certified of in column 1 and termination date,	iner transplant center, ent if applicable in column 2	er the certifi	cation dat	.e			133. 00
134.00 If this is an organ procurement or			n column 1				134. 00
and termination date, if applicabl							
All Providers							
140.00 Are there any related organization					Υ		140. 00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the				STS			
1. 00	2. 00		LI OHS)		3. 00		
If this facility is part of a chai			ugh 143 the	e name and		of the	
home office and enter the home off	fice contractor name and co	ntractor numb	er.				
141.00 Name: PARKVIEW HEALTH SYSTEM, INC			I ANS Contra	ctor's Nu	mber: 0810	)1	141. 00
440 0001 1 40504 0000000455 0011/5	•	RVI CE					1.10.00
142.00 Street: 10501 CORPORATE DRIVE 143.00 City: FORT WAYNE	PO Box: 560 State: IN	00	Zip Co	do	4684	1E	142. 00 143. 00
143. OUCITY. FORT WATNE	state. IN		ZIP CC	ue.	4004	13	143.00
						1. 00	
144.00 Are provider based physicians' cos	sts included in Worksheet A	?				Υ	144. 00
					1. 00	2. 00	
145.00 If costs for renal services are cl					N	N	145. 00
inpatient services only? Enter "Y"				5			
no, does the dialysis facility inc period? Enter "Y" for yes or "N"		TOT THIS COST	reporting				
146.00 Has the cost allocation methodolog		sty filed cost	t report?		N		146. 00
Enter "Y" for yes or "N" for no ir				lf			
yes, enter the approval date (mm/c			, ,				
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				or no		N N	148. 00 149. 00
149. 00 was there a change to the shillpitti	ed cost finding method? En	Part A	Part E		itle V	Title XIX	149.00
		1.00	2.00	, '	3.00	4.00	
Does this facility contain a provi	der that qualifies for an	exemption from	m the appli	cation of	f the lowe		
or charges? Enter "Y" for yes or '	'N" for no for each compone	nt for Part A	and Part I	3. (See 42	2 CFR §413	3. 13)	
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der – IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY		N N	l N		N	N	160. 00
161. 00 CMHC		14	l N		N	N	161. 00
			'				
						1.00	
Mul ti campus						1	4,5 5
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	or more campu	uses in dif	Terent CB	SAS?	N	165. 00
Enter 1 for yes of N For No.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each		00	2. 30	2.00	1. 55		0 166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1. 00	
Health Information Technology (HI	Γ) incentive in the America	n Recovery and	d Reinvestr	ment Act			
167.00 Is this provider a meaningful user	under §1886(n)? Enter "Y	" for yes or '	'N" for no.			Y	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a meaning	ful user (line		"), enter	the	21, 32	168.00
reasonable cost incurred for the H							1
168.01 If this provider is a CAH and is r					Ishi p		168. 01
exception under §413.70(a)(6)(ii)?					ntar the	0.0	00169.00
transition factor. (see instruction		із поса САП	(1116 100 1	3 N ), E	arter the	0.0	79 10 7. 00
10. a.i.s. 1. a.i. 1. a.a.a.i. (300 111311 dot110	···-,					1	1

Health Financial Systems	PARKVIEW WABASH HO	SPITAL, INC.	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310						
			From 01/01/2016				
			To 12/31/2016	Date/Time Pre 5/30/2017 11:			
			Begi nni ng	Endi ng			
			1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting				09/30/2016	170. 00		
period respectively (mm/dd/yyyy)							
			1. 00	2. 00			
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	0	171. 00		
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter					
"Y" for yes and "N" for no in colum	n 1. If column 1 is yes, e	nter the number of section	n				
1876 Medicare days in column 2. (se	e instructions)			İ			

Ν

N

Ν

Ν

18.00

19.00

18.00

19.00

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

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

Report data for corrections of other PS&R Report

cost report? If yes, see instructions.

information? If yes, see instructions.

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

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 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 5/30/2017 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				
	I	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	instructions			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	ing the cost	N	23. 00			
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	porting period?	N	24. 00					
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.	cost reportir	ng period? If	yes, submit	N	27. 00			
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into du	ring the cost	reporting	N	28. 00			
29. 00	period? If yes, see instructions.  Did the provider have a funded depreciation account and/or		· ·		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	uctions `		,	N	30.00			
	instructions.	,	,						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance or new	debt? IT yes	, 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	ıcti ons.	-		N	33. 00			
00.00	no, see instructions.  Provider-Based Physicians	Trou por turnir		trve brading. 11					
34. 00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed_physicians?	Υ	34.00			
35. 00	If yes, see instructions.  If line 34 is yes, were there new agreements or amended exi	o .	•	. ,	Y	35. 00			
35.00	physicians during the cost reporting period? If yes, see in		TIS WITH THE			35.00			
				Y/N 1. 00	2. 00				
	Home Office Costs			1.00	2.00				
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	epared by the	home office?	Y		37. 00			
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	N		38. 00			
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			. N		39. 00			
40. 00	see instructions.  If line 36 is yes, did the provider render services to the	•		N		40. 00			
10.00	instructions.	Tiome office.				10.00			
		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@F	PARKVI EW. COM	43. 00			
	report preparer in columns 1 and 2, respectively.								

Heal th	Financial Systems PARKVIEW WA	BASH	HOSPI TAL,	I NC.		In Lie	u of Form CMS	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Ξ	Provi	der CCN: 15-1310		ri od:	Worksheet S-	2
					To	om 01/01/2016 12/31/2016		
							070072017 11	TT GIII
				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 co	st						43. 00
	report preparer in columns 1 and 2, respectively.							

 
 Heal th Financial
 Systems
 PARKVIEW W

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-1310

Component   Worksheet A   No. of Beds   Bed Days   CAH Hours   Trips   Title V					To	12/31/2016	Date/Time Prep 5/30/2017 11:4	
Component								f i aiii
1.00							Visits / Trips	
1.00		Component		No. of Beds	,	CAH Hours	Title V	
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	1.00							
Hospice days)(see instructions for col. 2   for the portion of LDP room available beds)   2.00	1.00		30.00	25	9, 150	66, 960. 00	O O	1.00
For the portion of LIP room available beds)								
2.00								
4. 00	2.00							2.00
5.00   Hospital Adults & Peds. Swing Bed SNF   0   6.00   0   0   0   0   0   0   0   0   0	3.00	HMO IPF Subprovider						3.00
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 10. 00 BURNI INTENSIVE CARE UNIT 11. 00 SURRICAL INTENSIVE CARE UNIT 12. 00 THER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 43. 00 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE (non-distinct part) 25. 9, 150 66, 960. 00 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Observation Bed Days 29. 00 ABDULATIVE days (see instruction) 29. 00 Employee di scount days (see instructions) 30. 00 31. 00 32. 01 Total adults and Peds (exclude observation) 32. 01 Total adults and Peds (exclude observation by 10 of 0 o								
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions)								
beds) (see instructions)					0.450			
8. 00 INTENSIVE CARE UNIT	7. 00	`		25	9, 150	66, 960. 00	0	7. 00
9.00   CORONARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   11.00   11.00   SURGICAL INTENSIVE CARE UNIT   11.00   12.00   OTHER SPECIAL CARE (SPECIFY)   12.00   13.00   NURSERY   43.00   15.00   CAH visits   5   5   9,150   66,960.00   16.00   SUBPROVIDER - IPF   15.00   17.00   SUBPROVIDER - IRF   16.00   18.00   SUBPROVIDER - IRF   18.00   19.00   SKILLED NURSING FACILITY   20.00   20.00   NURSING FACILITY   21.00   21.00   OTHER LONG TERM CARE   22.00   22.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   24.00   HOSPICE (non-distinct part)   30.00   25.00   CMHC - CMHC   25.00   26.05   FEDERALLY QUALIFIED HEALTH CENTER   89.00   27.00   Total (sum of lines 14-26)   25.00   28.00   Ambul ance Trips   30.00   30.00   Employee discount days (see instruction)   31.00   31.00   Employee discount days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   SURROVIER   33.00   32.01   33.00   33.00   33.00   33.00   34.00   Complex descriptions   34.00   35.00   Complex descriptions   34.00   35.00   Complex descriptions   35.00   35.00   Complex descri	8 00	, ,						8 00
10. 00   BURN INTENSIVE CARE UNIT   11. 00     11. 00   SURGICAL INTENSIVE CARE UNIT   11. 00     12. 00   OTHER SPECIAL CARE (SPECIFY)   12. 00     13. 00   ONURSERY   43. 00   25   9, 150   66, 960. 00   0     14. 00   Total (see instructions)   25   9, 150   66, 960. 00   0     15. 00   CAH visits   0   15. 00     16. 00   SUBPROVIDER - IPF   16. 00     17. 00   SUBPROVIDER - IRF   17. 00     18. 00   SUBPROVIDER - IRF   18. 00     19. 00   SVILLED NURSING FACILITY   20. 00   NURSING FACILITY   20. 00     10. 00   OTHER LONG TERM CARE   21. 00     21. 00   OTHER LONG TERM CARE   22. 00   HOME HEALTH AGENCY   101. 00     23. 00   AMBULATORY SURGICAL CENTER (D. P. )   23. 00     24. 10   HOSPICE   10. 00   0   0     25. 00   CMHC - CMHC   25. 00     26. 25   FEDERALLY QUALIFIED HEALTH CENTER   89. 00     27. 00   Total (sum of lines 14-26)   25     28. 00   Observation Bed Days   0   28. 00     29. 00   Ambulance Trips   30. 00     30. 00   Employee discount days (see instruction)   31. 00     31. 00   Employee discount days (see instructions)   0   0     32. 00   Labor & delivery days (see instructions)   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0   0     10. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0   0     17. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0   0   0     17. 00   Total (and illary labor & delivery room outpatient days (see instructions)   0   0   0   0   0   0   0     18. 00   00   00   00   00   00   00   00								
11. 00 12. 00 17. 00 18. ON OTHER SPECIAL CARE (SPECIFY) 12. 00 18. 00 19. 00 1								
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 143. 00 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OWENING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 22. 00 Employee discount days (see instruction) 25. 00 Employee discount days (see instructions) 26. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		1						
14.00								
15. 00   CAH visits   0   15. 00   16. 00   SUBPROVI DER - I PF   17. 00   18. 00   SUBPROVI DER - I RF   18. 00   19. 00   SKILLED NURSING FACILITY   19. 00   20. 00   OTHER LONG TERM CARE   21. 00   22. 00   HOME HEALTH AGENCY   101. 00   23. 00   AMBULATORY SURGI CAL CENTER (D. P. )   24. 00   HOSPICE (non-distinct part)   30. 00   24. 10   HOSPICE (non-distinct part)   30. 00   26. 00   RURAL HEALTH CLINIC   25. 00   26. 00   RURAL HEALTH CLINIC   25. 00   26. 00   Observation Bed Days   27. 00   29. 00   Ambul ance Trips   30. 00   30. 00   Employee discount days - IRF   32. 01   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   32. 01   32. 01   Total ancillary labor & delivery room outpatient days (see instructions)   32. 01   34. 00   15. 00   16. 00   16. 00   16. 00   17. 00   18. 00   17. 00   19. 00   0   18. 00   19. 00   19. 00   19. 00   19. 00   19. 00   10. 00   0   0   10. 00   0   0   11. 00   0   0   12. 00   0   0   12. 00   0   0   13. 00   0   0   14. 00   0   0   15. 00   16. 00   16. 00   0   17. 00   0   18. 00   0   19. 00   0   19. 00   0   19. 00   0   10.	13.00	, ,	43. 00				0	13.00
16. 00 SUBPROVI DER - I PF 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 18. 00 SUBPROVI DER 19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 21. 00 AMBULATORY SURGICAL CENTER (D. P. ) 24. 00 HOSPI CE 24. 10 HOSPI CE 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trip bs 30. 00 31. 00 Empl oyee di scount days (see instruction) Empl oyee di scount days - I RF 32. 00 I ancillary labor & delivery room outpatient days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 32. 01  17. 00 18. 00 19	14.00	Total (see instructions)		25	9, 150	66, 960. 00	0	14.00
17. 00   SUBPROVIDER - IRF   17. 00   18. 00   SUBPROVIDER   19. 00   SUBLED NURSING FACILITY   19. 00   20. 00   NURSING FACILITY   20. 00   NURSING FACILITY   21. 00   22. 00   OTHER LONG TERM CARE   21. 00   22. 00   HOME HEALTH AGENCY   23. 00   AMBULATORY SURGICAL CENTER (D.P.)   23. 00   40. 00   HOSPICE   116. 00   0   0   0   24. 00   24. 10   HOSPICE (non-distinct part)   30. 00   24. 10   HOSPICE (non-distinct part)   30. 00   24. 10   25. 00   24. 10   25. 00   26. 25   27. 00   26. 25   27. 00   26. 25   27. 00   27. 00   28. 00   29. 00   25. 00   25. 00   26. 25   27. 00   27. 00   28. 00   29.	15. 00	CAH visits					0	15.00
18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee di scount days (see instruction) 31.00 Employee di scount days - IRF 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
19.00   SKILLED NURSING FACILITY   19.00   20.00   20.00   21.00   21.00   21.00   21.00   21.00   21.00   21.00   22.00   23.00   AMBULATORY SURGICAL CENTER (D.P.)   23.00   40.00								
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total days (see instructions) 30.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 40. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 29. 00 Employee discount days (see instruction) 20. 00 Employee discount days - IRF 20. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 116. 00 0 24. 10 HOSPICE 116. 00 0 24. 10 CMHC - CMHC 25. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 116. 00 0 0 0 24. 00 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 32. 01		1	101 00				ا	
24. 00 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) Employee discount days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			101.00				Ĭ	
25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 25. 00 26. 25 Total (sum of lines 14-26) 25 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions)			116. 00	0	0			
26. 00	24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27. 00 Total (sum of lines 14-26) 25 27.00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01								
27.00   Total (sum of lines 14-26)   25   27.00   28.00   29.00   28.00   29.0								
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01			89. 00				0	
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)				25				
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)  30.00 31.00 32.00		3					U	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  31.00 0 0 0 32.00								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  32.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)				0	0			
outpatient days (see instructions)				J				
	33. 00	LTCH non-covered days						33.00

 Heal th Financial
 Systems
 PARKVIEW V

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 15-1310

Peri od: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/30/2017 11: 41 am

		17F Days	/ O/P Visits	/ 111ps	Full Time E	equi vai ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	863	28	1, 755			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)	524	138				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	39	0	39			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	200	67	67			6. 00
7. 00	Total Adults and Peds. (exclude observation	902	95	1, 861			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		0	0			13. 00
14. 00	Total (see instructions)	902	95	1, 861	0.00	180. 20	
15. 00	CAH visits	702	,3	1, 001	0.00	100. 20	15. 00
16. 00	SUBPROVI DER - I PF	J	Ŭ	· ·			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	7, 329	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	180. 20	
28. 00	Observation Bed Days		64	513			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			13			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33.00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-1310

				To	12/31/2016	Date/Time Prep   5/30/2017 11:4	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	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		0	309	7	645	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			181	34		2.00
3.00	HMO IPF Subprovider				O		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
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	0	309	7	645	14.00
15. 00	CAH visits						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 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 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. )	0.00					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 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31. 00	Employee discount days (see Histruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

Heal th	Financial Systems PA	ARKVIEW WABASH H	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
	EALTH AGENCY STATISTICAL DATA			CN: 15-1310 CCN: 15-7061	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-4  Date/Time Pre 5/30/2017 11:	pared:
					Home Health	PPS	
					Agency I		
					1.	00	
0.00	County	T: +1 - 1/	T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	T: +1 - VIV	0+1	T-+-1	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	01.00	l	0 0		
2. 00	Unduplicated Census Count (see instructions)	0.00	81. 00		0.00 ployees (Full Ti		2. 00
				Tramber of Em	project (run n	me Equi vai ent)	
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal			551111 451		
		0	ı	1.00	2. 00	3. 00	
2 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		2 22		20 22	2.22	
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0. 00	0. (			1
5. 00	Other Administrative Personnel			0. (		•	1
6.00	Direct Nursing Service			0.0		•	1
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0		•	1
9. 00	Physical Therapy Supervisor			0.0		•	1
10.00	Occupational Therapy Service			0. (		l .	1
11.00	Occupational Therapy Supervisor			0.0			
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0		l	12. 00 13. 00
14. 00	Medical Social Service			0.0			14. 00
15. 00	Medical Social Service Supervisor			0.0		l .	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. (		l .	16. 00 17. 00
18. 00	Other (specify)			0.0		1	18. 00
	HOME HEALTH AGENCY CBSA CODES						
19. 00	Enter in column 1 the number of CBSAs where				1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			99915			20. 00
	during this cost reporting period (line 20						
	contains the first code).	Full Ep	i sodes				
			With Outliers	LUPA Epi sode	es PEP Only	Total (cols.	
		Outliers	2.00	3.00	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	493	C		11 1	505	1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	78, 423 657	(		16 139 5 20	l	1
24. 00	Physical Therapy Visits  Physical Therapy Visit Charges	102, 250	C	1	73 2, 908	<b>l</b>	
25. 00	Occupational Therapy Visits	116	C	1	3 0	119	25. 00
26.00	Occupational Therapy Visit Charges	17, 087	C	1	20 0	17, 507	1
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	22 2, 765	(	1	0 0	22 2, 765	
29. 00	Medical Social Service Visits	1	C		0 0	1	29. 00
30. 00	Medical Social Service Visit Charges	94	C	•	0 0	94	1
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	11 896	(	•	0 0	11 896	1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	1, 300	(	1	19 21	l	33. 00
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 201, 515	C	3, 00	0 0 09 3, 047	207 571	1
აა. 00	30, 32, and 34)	201, 515	C	3,00	3, 04/	207, 571	35. 00
36. 00	Total Number of Episodes (standard/non	0			0 0	0	36. 00
37. 00	outlier) Total Number of Outlier Episodes					_	37. 00
	Total Non-Routine Medical Supply Charges	О	C	ó	0 0		38.00
	1	, -1		•	,	,	

Heal th	Financial Systems	P/	ARKVIEW WABASH	HOSPITAL INC		In lie	u of Form CMS-2	2552-10
	AL-BASED HOSPICE IDENTIFICATION		WINNER WINDHOLL	Provi der Co		Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-9 PARTS I THROU	GH IV pared:
						Hospi ce I	07 007 2017 111	TT GIII
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1. 00	2.00	Facility 3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO					3.00	0.00	
1.00	Hospice Continuous Home Care	JOT KEI OKTING I	LKI ODS BEGINNI	NO BEFORE OCTO	DER 1, 2013			1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
	hospi ce care							
7. 00	Total number of unduplicated							7. 00
	Continuous Care hours billable to Medicare							
8. 00	Average Length of Stay (line 5							8.00
0.00	/ line 6)							0.00
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.	•		
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,		_	
10.00	Hospice Continuous Home Care			4 (00		0 0		10.00
11. 00	Hospice Routine Home Care			4, 622	1	65 259		11.00
12. 00 13. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care			17	1	0 4		12. 00 13. 00
14. 00	1 .			4, 675		65 263		14. 00
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					14.00
15. 00		5/1// 10// 000	JEI OKITINO I E	C C		0 0		15. 00
	Hospice General Inpatient Care					0 0		16. 00
				•	•	1	'	•

	Financial Systems PARKVIEW WABASH HO				eu of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	N: 15-1310	Peri od: From 01/01/2016	Worksheet S-10	0
				To 12/31/2016		pared: 41 am
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lir	ne 202 column	1 8)	0. 303949	1.00
00	Medicaid (see instructions for each line)	. 0)	0.000717			
2.00	Net revenue from Medicaid		868, 246	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement	al payments f	from Medicaio	1?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments fr	om Medicaid			67, 510	5. 00
6.00	Medi cai d charges				7, 489, 350	6. 00
7.00	Medicaid cost (line 1 times line 6)				2, 276, 380	7. 00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of lir	nes 2 and 5; if	1, 340, 624	8. 00
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions</pre>	£   !	- \			
9. 00	Net revenue from stand-alone CHIP	ror each rine	e)		0	9.00
10. 00	Stand-alone CHIP charges					10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mir	nus line 9: i	f < zero then	0	12.00
	enter zero)	(				
	Other state or local government indigent care program (see in	structions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not in				1, 560, 321	
14. 00	Charges for patients covered under state or local indigent ca	re program (N	Not included	in lines 6 or	8, 336, 555	14. 00
45.00	10)	4.43			0 500 000	45.00
15. 00 16. 00	State or local indigent care program cost (line 1 times line Difference between net revenue and costs for state or local i		program (Li	o 15 minus lino	2, 533, 888 973, 567	15. 00 16. 00
16.00	13; if < zero then enter zero)	ndigent care	program (III	ie io illitius title	973, 307	16.00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to	fundi ng chari	ty care		0	17. 00
18.00	Government grants, appropriations or transfers for support of	hospital ope	erati ons		0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loc	al indigent o	care programs	s (sum of lines	2, 314, 191	19. 00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00	
20. 00	Charity care charges for the entire facility (see instruction	5)	648, 20			20. 00
21. 00	Cost of patients approved for charity care (line 1 times line	,	197, 0			
22. 00	Partial payment by patients approved for charity care	20)	.,,,	0 1, 154		
	Cost of charity care (line 21 minus line 22)		197, 0			
					1.00	
24. 00	Does the amount in line 20 column 2 include charges for patie		nd a Length o	of stay limit		24. 00
25 00	imposed on patients covered by Medicaid or other indigent car		amomic i	h of oter limit		25 00
25. 00 26. 00	If line 24 is "yes," charges for patient days beyond an indi		ogram s reng	n or stay iimit	0	25. 00 26. 00
	Total bad debt expense for the entire hospital complex (see i				3, 582, 837 267, 986	1
27. 00 28. 00	Medicare bad debts for the entire hospital complex (see instr Non-Medicare and non-reimbursable Medicare bad debt expense (		Lino 27)		3, 314, 851	1
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (			28)	1, 007, 546	
	Cost of uncompensated care (line 23 column 3 plus line 29)	Apense (Title	i times time	, 20)	1, 371, 435	
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			3, 685, 626	
200	1.2.2. 2 2				0,000,020	, 300

Health Financial Systems	PARKVIEW WABASH H	OSPITAL, INC.	In Lieu of Form CMS-2552				
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der Co		eri od:	Worksheet A		
				rom 01/01/2016	D-+- /T: D		
				o 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 41 am	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed		
			+ col . 2)	ons (See A-6)	Trial Balance		
			,	, ,	(col. 3 +-		
					col . 4)		
	1.00	2.00	3. 00	4. 00	5. 00		
GENERAL SERVICE COST CENTERS							
1.00 O0100 CAP REL COSTS-BLDG & FLXT		5, 031, 983	5, 031, 983		4, 934, 276	1. 00	
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		0	(	,	722, 570	2. 00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	82, 298	3, 989, 153			4, 070, 838	4. 00	
5.00 00500 ADMINISTRATIVE & GENERAL	599, 146	13, 291, 983			13, 740, 807	5. 00	
7.00 OO700 OPERATION OF PLANT	291, 273	811, 394			1, 096, 946	7. 00	
8.00   00800 LAUNDRY & LINEN SERVICE	0	0		ή	0	8. 00	
9. 00   00900   HOUSEKEEPI NG	206, 891	206, 913	1		413, 804	9. 00	
10. 00   01000   DI ETARY	430, 027	245, 248	675, 275		198, 634	10.00	
11. 00   01100   CAFETERI A	455.7(0)	0	4// 700	472, 126	472, 126	11.00	
13. 00 01300 NURSI NG ADMI NI STRATI ON	155, 760	11, 023	1		166, 446	13.00	
14. 00 01400 CENTRAL SERVICES & SUPPLY	(22, 450	220	l .		220	14.00	
15. 00   01500   PHARMACY	622, 450	2, 462, 696	1		1, 061, 344	15.00	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	(	)l O	0	16. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00   03000   ADULTS & PEDI ATRI CS	1, 185, 182	207, 939	1, 393, 121	-1, 812	1, 391, 309	30.00	
43. 00   04300   NURSERY	1, 165, 162	207, 939	1		1, 391, 309	43. 00	
ANCI LLARY SERVI CE COST CENTERS	l ol		1	) U	U	43.00	
50. 00 05000 OPERATING ROOM	583, 180	450, 799	1, 033, 979	-117, 088	916, 891	50.00	
51. 00   05100   RECOVERY   ROOM	303, 100	430, 777	1,055,777	117,000	0	51.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0			0	52. 00	
53. 00   05300   ANESTHESI OLOGY		44	44	-201	-157	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	818, 206	857, 605			1, 675, 448	54.00	
56. 00   05600   RADI OI SOTOPE	010, 200	007,000	1,0,0,0,0	0	0	56. 00	
60. 00   06000   LABORATORY	o	1, 317, 573	1, 317, 573	-3	1, 317, 570	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0	,,,,,,,,	0	0	63. 00	
66. 00   06600 PHYSI CAL THERAPY	956, 353	132, 365	1, 088, 718	-83, 722	1, 004, 996	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	,	79, 086		67. 00	
68. 00 06800 SPEECH PATHOLOGY	O	0	ıl c	0	0	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	531, 649	32, 143	563, 792	-9, 101	554, 691	69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	659, 906	659, 906	-226, 555	433, 351	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	(	226, 327	226, 327	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	74	74	1, 992, 071	1, 992, 145	73. 00	
OUTPATIENT SERVICE COST CENTERS							
90. 00  09000  CLI NI C	0	151, 906			156, 230	90. 00	
90. 01   09001   SENI OR CARE	134, 357	93, 604	1		227, 961	90. 01	
91. 00  09100 EMERGENCY	684, 106	2, 364, 128	3, 048, 234	-1, 534	3, 046, 700	91. 00	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00	
OTHER REIMBURSABLE COST CENTERS			1				
101. 00 10100 HOME HEALTH AGENCY	620, 577	117, 652	738, 229	0	738, 229	101. 00	
SPECIAL PURPOSE COST CENTERS		201 200					
113. 00 11300   INTEREST EXPENSE	007 505	301, 839				113.00	
116. 00 11600 HOSPI CE	237, 535	171, 016	408, 551	0	408, 551		
118. 00 SUBTOTALS (SUM OF LINES 1-117)	8, 138, 990	32, 909, 206	41, 048, 196	-857	41, 047, 339	1118.00	
NONREI MBURSABLE COST CENTERS			J		0	100 00	
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	20. 725	2 700	42 515	0		190.00	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	39, 735	3, 780	43, 515			192.00	
194. 00 07950 FITNESS CENTER 194. 01 07951 FOUNDATION	0	710	716			194. 00 194. 01	
194.01 07951 FOUNDATION 194.02 07952 NEW DIRECTION	- 1	-719	-719 c			194. 01	
194. 02 07952 NEW DIRECTION 194. 03 07953  COMMUNITY & VOLUNTEER SERVICES	0	72, 018	72, 018		72, 018		
194. 04 07954 WELL CHILD CLINIC		/∠, UI8	12,018			194. 03	
194. 05 07955 OCCUPATI ONAL HEALTH		0		857		194. 04	
200. 00 TOTAL (SUM OF LINES 118-199)	8, 178, 725	32, 984, 285	41, 163, 010				
200.00   101AL (00M OF LINES 110-177)	1 0, 170, 725	52, 704, 200	1 -1, 103, 010	'I O	+1, 103, 010	1200.00	

 
 Health Financial
 Systems
 PARKVIEW WABA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-1310 Peri od: 

				5/30/2017 11:	
	Cost Center Description	Adjustments	Net Expenses	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
	<b>'</b>		For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-4, 476, 029	458, 247	1	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-67, 208	655, 362	!	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-863, 854	3, 206, 984		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-6, 673, 459	7, 067, 348	3	5. 00
7.00	00700 OPERATION OF PLANT	-67, 462	1, 029, 484	,	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	)	8. 00
9.00	00900 HOUSEKEEPI NG	0	413, 804	,	9. 00
10.00	01000 DI ETARY	0	198, 634	,	10. 00
11. 00	01100 CAFETERI A	-184, 794	287, 332		11. 00
13.00	01300 NURSING ADMINISTRATION	0	166, 446		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	220	)	14. 00
15. 00	01500 PHARMACY	-366, 752	694, 592	!	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	)	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	8, 236	1, 399, 545		30. 00
43.00	04300 NURSERY	0	0	)	43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	916, 891		50.00
51. 00	05100 RECOVERY ROOM	0	0	•	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	52. 00
53.00	05300 ANESTHESI OLOGY	0	-157	•	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-248, 646	1, 426, 802	!	54. 00
56. 00	05600 RADI OI SOTOPE	0	0	1	56. 00
60.00	06000 LABORATORY	-129, 106	1, 188, 464		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	)	63. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 004, 996		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	79, 086	)	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	554, 691	•	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	433, 351		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	226, 327		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 992, 145	)	73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	156, 230		90.00
90. 01	09001 SENI OR CARE	0	227, 961	I and the second	90. 01
91. 00	09100 EMERGENCY	-657, 769	2, 388, 931		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS				4
101.00	10100 HOME HEALTH AGENCY	0	738, 229	1	101. 00
440.00	SPECIAL PURPOSE COST CENTERS				140.00
	11300   INTEREST EXPENSE	0	0	·	113.00
	11600 HOSPI CE	0	408, 551	i de la companya del companya de la companya de la companya del companya de la co	116.00
118.00	,	-13, 726, 843	27, 320, 496	· <u> </u>	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0		100.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42 515	l e e e e e e e e e e e e e e e e e e e	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	43, 515	l e e e e e e e e e e e e e e e e e e e	192.00
	07950 FITNESS CENTER	0	710	l e e e e e e e e e e e e e e e e e e e	194. 00
	07951   FOUNDATI ON 2 07952   NEW DI RECTI ON	0	-719 0		194. 01 194. 02
		0	•		194. 02
	3 07953 COMMUNITY & VOLUNTEER SERVICES   07954 WELL CHILD CLINIC	1	72, 018	l e e e e e e e e e e e e e e e e e e e	
	07954 WELL CHILD CLINIC 07955 OCCUPATIONAL HEALTH	0	0 857		194. 04 194. 05
200.00		1		•	200. 00
200.00	DI LOTAL (SOM OF LIMES 110-144)	-13, 726, 843	27, 436, 167	I	J200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1310 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

Cost Center						10	30/2017 11:41 am
A - REHAM THERAMY NICLASS   6.7 00			Increases				 00, 201, 111 11 4
A. RETHAN THERAPY PECLASS		Cost Center	Li ne #	Sal ary	0ther		
1.00   CCUPATIONAL THERAPY   67.00   69,478   9,616   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,616   9,6178   9,617			3.00	4. 00	5. 00		
0							
B - CLINIC DIFFICIAN	1. 00	OCCUPATI ONAL THERAPY	<u>67.</u> 00				1.00
1.00   C CAFETERIA RECLASS		0		69, 478	9, 616		
1.00   CAFETERIA RECLASS   11.00   299.553   172.573   12.00   1.00							
C - CAPETERIA RECLASS  1 00	1.00	CLINIC	90.00		0		1.00
1.00		0		4, 324	0		
O   DRUGS CHARGED TO PATIENTS   1.00   0   1,992,071   1.00   3.00   3.00   3.00   3.00   3.00   4.00   3.00   4	1 00		11 00	200 552	170 570		1.00
D - DRUGS CHARGED TO PATIENTS   73.00   0   1.992,071   1.00   2.00   RADIOLOGY-DIAGNOSTIC   54.00   0   0   0   0   0   3.00   4.00   0   0   0   0   3.00   4.00   0   0   0   0   0   3.00   4.00   0   0   0   0   0   3.00   4.00   0   0   0   0   0   3.00   4.00   0   0   0   0   0   3.00   4.00   0   0   0   0   0   0   0   3.00   4.00   0   0   0   0   0   0   0   0   0	1.00	CAFE IERI A					1.00
1.00		D DDUCE CHARGED TO DATI FAITE		299, 553	172, 573		
2.00   AGIOLOGY-DI AGNOSTIC   54,00   0   66   0   0   0   0   0   0   0	1 00		72 00	٥	1 002 071		1 00
3.00 4.00 0			l l	0			•
1.00		RADI OLOGI - DI AGNOSTI C	l l	0			1
1.00				0			1
1.00	4.00			_ — — 🕌			4.00
1.00		F - SALARY RECLASS		٥	1, 772, 107		
1.00   CAP REL COSTS-MYBLE EQUIP   2.00   0.00	1 00		5 00	2 425 401	0		1 00
COLUPATI ONAL HEALTH		0			— — <u> </u>		
1.00		F - OCCUPATIONAL HEALTH					
2.00 3.00 4.00 5.00 6.00 6.00 7.00 8.00 0.00 0.00 0.00 0.00 0.00 0	1.00		194. 05	0	857		1. 00
4. 00	2.00		0.00	0	0		2. 00
5.00	3.00		0.00	0	0		3. 00
6.00	4.00		0.00	0	0		4. 00
7. 00	5.00		0.00	O	0		5. 00
8. 00    Columb	6.00		0.00	0	0		6. 00
1.00	7.00		0.00	0	0		7. 00
1.00	8.00		0.00		0		8. 00
1.00		0		0	857		
Note							
H - EQUIP & BLDG LEASE	1. 00	CAP REL COSTS-MVBLE EQUIP					1.00
1. 00 CAP REL COSTS-BLDG & FIXT		0		0	518, 417		
2. 00	1 00		4 00		05.000		4.00
3. 00 4. 00 5. 00 6. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 10. 00 11. 00 12. 00 12. 00 12. 00 13. 00 14. 00 9. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 9. 00 10				-			
4.00 5.00 6.00 0.00 0.00 0.00 0.00 7.00 8.00 8.00 9.00 0.00 0.00 0.00 0.00 0		CAP REL COSTS-MVBLE EQUIP		-1			
5. 00 6. 00 0. 00			l l	-1			1
6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 10. 00 11. 00 11. 00 12. 00 0 11. 00 12. 00 0 13. 00 0 14. 00 0 15. 00 0 15. 00 0 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l	0	0		•
7. 00 8. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0			l l	0	0		1
8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l	0	0		
9. 00 10. 00 10. 00 10. 00 11. 00 11. 00 11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l	0	0		
10. 00 11. 00 11. 00 12. 00 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l	0			
11. 00 12. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0			
12.00				-1			
1.00   IMPL. DEV. CHARGED TO   72.00   0   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   1.00   226, 327   2.00   3, 978   1.00   3, 978   1.00   3, 978   1.00   3, 978   1.00   2, 00   3, 978   1.00   2, 00   3, 978   1.00   2, 00   2, 3, 349   1.00   2, 00   2, 3, 349   1.00   2, 00   2, 3, 349   1.00   2, 00   2, 3, 349   1.00   2, 00   2, 3, 349   2.00   1.00   2, 3, 349   1.00   2, 3, 349   1.00   2, 3, 349   3, 34				-1	0		
I - IMPLANTABLE MEDICAL SUP.   1.00			+		266, 604		12.00
1. 00		I - IMPLANTABLE MEDICAL SUP.		3	,		
PATI ENTS	1.00		72. 00	O	226, 327		1. 00
1.00   CAP REL COSTS-BLDG & FIXT   1.00   0   3,978   0   0   3,978		PATI ENTS					
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 3,978 1.00    K - INTEREST EXPENSE 1.00 0 301,839 1.00    TOTALS 0 301,839 1.00    L - INSURANCE 1.00 0 29,093 1.00    CAP REL COSTS-BLDG & FIXT 1.00 0 29,093 1.00    2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 23,349 1.00    TOTALS 0 52,442				0	226, 327		
Totals   T							
1.00   CAP REL COSTS-BLDG & FIXT   1.00   0   301,839   1.00	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 978	·	1.00
1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 301, 839 1. 00 TOTALS 0 301, 839 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 29, 093 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 29, 093 1. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 23, 349 1. 00 52, 442		0		0	3, 978		
TOTALS 0 301, 839  L - I NSURANCE  1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 0 29, 093 1. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 0 23, 349 2. 00 TOTALS 0 52, 442		K - INTEREST EXPENSE					
L - I NSURANCE  1. 00	1.00		1.00				1. 00
1. 00				0	301, 839		
2. 00 CAP REL COSTS - MVBLE EQUIP 2. 00 23, 349 52, 442		L - I NSURANCE					
TOTALS 0 52, 442				0			1. 00
TOTALS         0         52, 442           500. 00 Grand Total: Increases         2, 798, 756         3, 544, 790           500. 00         500. 00	2.00						2. 00
500.00   Grand Total: Increases     2,798,756  3,544,790	505 -			0	52, 442		
	500.00	Grand Total: Increases		2, 798, 756	3, 544, 790		500. 00

Provider CCN: 15-1310 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

		Decreases		, , , , , , , , , , , , , , , , , , ,			017 11: 41 a
	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						
00	PHYSICAL THERAPY	<u>66.</u> 00	6 <u>9, 4</u> 78	<u>9, 6</u> 16		<u>)</u>	1.
	0		69, 478	9, 616			
	B - CLINIC DIETICIAN				1		
0	DI ETARY	1000	4, 324	0		<u>]</u>	1
	0		4, 324	0			
_	C - CAFETERIA RECLASS	40.00	200 550	470 570	1	-T	
0	DI ETARY	1000	299, 553	17 <u>2, 5</u> 73		<u> </u>	1
	0		299, 553	172, 573			
_	D - DRUGS CHARGED TO PATIENTS	45.00	al	4 004 007	1	-T	
-	PHARMACY	15.00	0	1, 991, 896			1
	ADULTS & PEDIATRICS	30.00	0	11			2
0	MEDICAL SUPPLIES CHARGED TO	71. 00	0	184	(	)	3
_	PATI ENT	04.00		4.4			
0	EMERGENCY	<u>91.</u> 00		46		4	4
	U PECLACC		0	1, 992, 137			
_	E - SALARY RECLASS	5.00	ما	2 425 401		٦	
0	ADMI NI STRATI VE & GENERAL	5.00	0	2, 425, 401		<u>)</u>	1
	F - OCCUPATIONAL HEALTH		U	2, 425, 401			
0	ANESTHESI OLOGY	53.00	O	201			1
	RADI OLOGY-DI AGNOSTI C	54.00	Ol				2
0	LABORATORY	60.00	0	24			
	ELECTROCARDI OLOGY	69.00	0	3			3
0	PHYSI CAL THERAPY	66.00	0	151			5
	OCCUPATIONAL THERAPY	67.00	0	18 8			6
	MEDICAL SUPPLIES CHARGED TO	71.00	0			-	
0	PATIENT	71.00	٥	44		7	7
0	EMERGENCY	91.00	0	408			8
.0	n like the transfer of the tra					4	'
	G - DEPRECIATION		<u> </u>	037			
	CAP REL COSTS-BLDG & FIXT	1.00	O	518, 417	Ç	ol .	1
•	0		— — <del>ŏ</del>	518, 417		<u>/</u>	1 '
	H - EQUIP & BLDG LEASE		<u>~</u>	0.0,			
0	RADI OLOGY-DI AGNOSTI C	54.00	0	405	10	וס	1
	ADMINISTRATIVE & GENERAL	5. 00	o	93, 902			2
	OPERATION OF PLANT	7. 00	o	5, 721		ol	3
	DI ETARY	10. 00	o	191			4
	NURSING ADMINISTRATION	13. 00	o	337			5
0	PHARMACY	15. 00	o	31, 906			1 6
	ADULTS & PEDIATRICS	30.00	0	1, 801	10		7
	OPERATING ROOM	50. 00	o	117, 088			8
	ELECTROCARDI OLOGY	69. 00	o	8, 950			9
	PHYSI CAL THERAPY	66.00	o	4, 610			10
	EMERGENCY	91.00	o	1, 080			11
	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	613			12
	0			266, 604		-	'-
	I - IMPLANTABLE MEDICAL SUP.		-1				
0	MEDICAL SUPPLIES CHARGED TO	71.00	0	226, 327		ol	1
-	PATI ENT		1	,			
				226, 327		1	i
	J - RECLASS TAXES						
0	ADMINISTRATIVE & GENERAL	5. 00	0	3, 978	13	3	1
	0 — — — — —	+	<del> </del>	3, 978		7	
	K - INTEREST EXPENSE				•		
	INTEREST EXPENSE	113.00	0	301, 839	11	1	1
	TOTALS	+		301, 839		7	
	L - INSURANCE		-1	. ,			
0	ADMINISTRATIVE & GENERAL	5. 00	Ol	52, 442	12	2	1
0		0.00	o	. 0	12		2
0 1	TOTALS — — — —			52, 442		→	-

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 01/01/2016 Part I 12/31/2016 Date/Time Prepared: 5/30/2017 11:41 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 295, 014 0 1.00 0 0 2.00 Land Improvements 314, 699 0 0 2.00 3.00 12, 586, 529 3.00 Buildings and Fixtures 0 0 0 4.00 Building Improvements 4, 150, 859 0 0 0 4.00 5.00 Fixed Equipment 921, 093 0 0 5.00 0 6.00 Movable Equipment 14, 017, 237 563, 426 563, 426 409, 071 6.00 0 7.00 HIT designated Assets 2, 108, 409 21, 329 21, 329 0 7.00 8.00 Subtotal (sum of lines 1-7) 35, 393, 840 584, 755 0 584, 755 409, 071 8.00 9.00 Reconciling Items -34, 780 -10, 046 0 -10, 046 -34, 780 9.00 Total (line 8 minus line 9) 35, 428, 620 594, 801 594, 801 443, 851 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, 295, 014 1.00 2.00 Land Improvements 314, 699 198, 753 2.00 . Buildings and Fixtures 12, 586, 529 3.00 12, 554, 011 3.00 4, 150, 859 2, 707, 213 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 921, 093 626, 750 5.00 14, 171, 592 11, 112, 135 6.00 Movable Equipment 6.00 1, 476, 650 7. 00 7.00 HIT designated Assets 2, 129, 738

35, 569, 524

35, 579, 570

-10, 046

28, 675, 512

28, 675, 512

Heal th	Financial Systems PA	ARKVIEW WABASH H	HOSPITAL, INC.		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-1310	Peri od:	Worksheet A-7		
					From 01/01/2016 To 12/31/2016		nared:	
					10 12/31/2010	5/30/2017 11:	41 am	
			SU	IMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
	'	'			instructions)			
		9. 00	10.00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	· · · · · · · · · · · · · · · · · · ·	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	5, 031, 983	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	5, 031, 983	0		0 0	0	3. 00	
		SUMMARY OF	F CAPITAL					
	Cost Center Description	Other 7	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, COLUMI	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	5, 031, 983			ļ	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2. 00	
3.00	Total (sum of lines 1-2)	0	5, 031, 983			ļ	3. 00	

0 0 0

5, 031, 983

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	ı Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	1	Period: From 01/01/2016 Fo 12/31/2016	oared:	
		COMI	PUTATION OF RAT	TIOS	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 CE	ENTERS			<u> </u>		
1.00	CAP REL COSTS-BLDG & FLXT	19, 268, 194	0	19, 268, 19	0. 576206	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 171, 592	0	14, 171, 592	0. 423794	0	2.00
3.00	Total (sum of lines 1-2)	33, 439, 786	0	33, 439, 786	1. 000000	ol	3.00
		ALLOCATION OF OTHER CAPITAL			SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(	335, 680	85, 800	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	) (	451, 209	180, 804	2.00
3.00	Total (sum of lines 1-2)	0	0	) (	786, 889	266, 604	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				ĺ	d Costs (see	through 14)	
					instructions)	• '	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	3, 696	29, 093	3, 978	3 0	458, 247	1.00
2 00	CAD DEL COSTS MADLE FOLLID		22 240		n n	/ 55 2/2	2 00

0 3, 696

29, 093 23, 349 52, 442

3, 978 0 3, 978

458, 247 1. 00 655, 362 2. 00 1, 113, 609 3. 00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1310 Peri od: Worksheet A-8 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/30/2017 11:41 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.00 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce -4, 317 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provi der-based physician -657, 769 10.00 A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -6, 475, 006 12.00 transactions (chapter 10) 13 00 0 00 Laundry and linen service 13 00 14.00 Cafeteria-employees and guests В -184, 794 CAFETERI A 11.00 14.00 15.00 15.00 Rental of quarters to employee 0.00 and others 0.00 16.00 16.00 Sale of medical and surgical supplies to other than pati ents 17.00 Sale of drugs to other than В -366, 752 PHARMACY 15.00 0 17.00 pati ents 18.00 Sale of medical records and 0 0.00 18.00 abstracts Nursing school (tuition, fees, 19.00 19 00 0 00 books, etc.) 20.00 Vending machines В -511 OPERATION OF PLANT 7.00 20.00 Income from imposition of 21.00 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0 00 22 00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory 0 \*\*\* Cost Center Deleted \*\*\* 23.00 23.00 A - 8 - 365.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 66.00 24.00 A-8-3 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 \*\*\* Cost Center Deleted \*\*\* 114.00 25.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL O 26.00 1.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00 Physicians' assistant 29 00 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 99 Hospice (non-distinct) (see 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 68 00 31.00 A - 8 - 3pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest 33 00 DEPRECIATION - - HIT ASSETS -53, 507 ADMINISTRATIVE & GENERAL 33 00 5 00 Α

2016

					5 12/31/2016	5/30/2017 11:	
				Expense Classification on	Worksheet A	37 307 2017 11.	71 GIII
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	DEPRECIATION HIT ASSETS	A	-67, 208	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 01
	PRI OR						
38. 00	SELF INSURANCE ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00		
39. 00	LOBBYI NG	A	·	ADMINISTRATIVE & GENERAL	5. 00		39. 00
40. 00	MARKETI NG	A		ADMINISTRATIVE & GENERAL	5. 00		40. 00
42. 00	LI QUOR ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00	l	42. 00
44. 00	DEPRECIATION REDUCTION FOR	A	-4, 177, 886	CAP REL COSTS-BLDG & FIXT	1. 00	9	44. 00
	ACCELERAT		0.001				45 00
45. 00	TELEMETRY MONITORING	A	·	ADULTS & PEDIATRICS	30. 00		45. 00
	FI TNESS CENTER	В	·	EMPLOYEE BENEFITS DEPARTMENT	4.00		45. 01
45. 02		A		ADMI NI STRATI VE & GENERAL	5. 00		45. 02
46. 01	CAPITALIZED INTEREST EXPENSE	A	·	CAP REL COSTS-BLDG & FIXT	1.00		46. 01
48. 00	OTHER OPERATING REV	A	·	RADI OLOGY-DI AGNOSTI C	54.00		48. 00
49. 00	OTHER OPERATING REV	A	·	LABORATORY	60.00		49. 00
49. 01	REMOVE EMS INTERSUBISDY	A	·	ADMI NI STRATI VE & GENERAL	5. 00		49. 01
49. 05		В	·	OPERATION OF PLANT	7. 00	0	49. 05
50. 00	,		-13, 726, 843				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> 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.

1. 00 4.00 5.00 2.00 3.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE ALLOCATION 1.00 5, 162, 840 5, 884, 000 1.00 5. OO ADMINISTRATIVE & GENERAL RELATED PARTY SUBSIDY ADJ. 2.00 5.753.846 2.00 C 3.00 0.00 0 3.00 4.00 0.00 0 4.00 5.00 TOTALS (sum of lines 1-4). 5, 162, 840 11, 637, 846 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.

 p		and I did, of 2, the amount difference of characters and action in containing for the party									
			Related Organization(s) and/	or Home Office							
Symbol (1)	Name	Percentage of	Name	Percentage of							
		Ownershi p		Ownershi p							
1. 00	2. 00	3. 00	4. 00	5. 00							
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:									

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

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

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

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

Heal th	Financial Syste	ems	ſ	PARKVIEW WABASH HO		In Lieu of Form CMS-2552-1			
STATEME OFFI CE		SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provider CCN: 1		Peri od: From 01/01/2016 To 12/31/2016	Worksheet A	Prepared:
	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.							
	6. 00	7.00	AENTO DEOUI DED	AC A DECILIT OF TD	ANCACTIONS WITH F	DELATED OF	DCANLIZATIONS OF (	SLAIMED.	
	HOME OFFICE CO		MENIS REQUIRED	AS A RESULT OF TR	ANSACITUNS WITH F	RELATED OF	RGANIZATIONS OR C	JLAI MED	
1. 00 2. 00 3. 00 4. 00 5. 00	-721, 160 -5, 753, 846 0 0 -6, 475, 006	0 0 0							1. 00 2. 00 3. 00 4. 00 5. 00
appropr	i ate. Posi ti ve	amounts increas	se cost and neg	oropriate) are tran gative amounts dec Yor 2, the amount a	rease cost.For re	elated org	ganization or hom	e office co	st which
	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
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1310

									То	12/31/2016	Date/Time Pre 5/30/2017 11:	
	Wkst. A Line #		Cost	Center/Physi ci an	Total	Pro	ofessi onal	Provi der		RCE Amount	Physi ci an/Prov	TI dili
				I denti fi er	Remuneration		omponent	Component			ider Component	
							·				Hours	
	1. 00			2. 00	3.00		4. 00	5. 00		6. 00	7. 00	
1.00	91. 00				40, 000		0			0	0	1. 00
2.00	91. 00				1, 629, 360		657, 769	971, 59	1	0	0	2.00
3.00	30.00				11, 284		0			0	0	3.00
4.00	90. 01	DR.	D		19, 050		0	19, 05	0	0	0	4.00
5.00	0. 00				0		0		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		o	0	0	8. 00
9.00	0.00				0		0		o	0	0	9. 00
10.00	0.00				0		0		o	0	0	10.00
200.00					1, 699, 694		657, 769	1, 041, 92	5		0	200.00
	Wkst. A Line #		Cost	Center/Physician	Unadjusted RCE	5 F	Percent of	Cost of		Provi der	Physician Cost	
				I denti fi er	Limit	Unac	djusted RCE	Memberships 8	š .	Component	of Mal practice	
							Limit	Continuing	S	hare of col.	Insurance	
								Educati on		12		
	1. 00			2.00	8. 00		9. 00	12. 00		13. 00	14. 00	
1.00	91. 00				0		0		0	0	0	1.00
2.00	91. 00				0		0		이	0	0	2. 00
3.00	30. 00				0		0		이	0	0	3. 00
4.00	90. 01	DR.	D		0		0		0	0	0	4.00
5.00	0.00				0		0		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					0		0		0	0	0	200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Provi der	Adj	usted RCE	RCE		Adjustment		
				I denti fi er	Component		Limit	Di sal I owance				
					Share of col.							
					14				$\perp$			
	1. 00			2. 00	15. 00		16. 00	17. 00		18. 00		
1.00	91. 00				0		0		0	0		1. 00
2.00	91. 00				0		0		0	657, 769		2. 00
3.00	30. 00				0		0		0	0		3. 00
4.00	90. 01		D		0		0		이	0		4. 00
5.00	0. 00				0		0		0	0		5. 00
6.00	0. 00				0		0		0	0		6.00
7.00	0. 00				0		0		0	0		7.00
8.00	0. 00				0		0		0	0		8.00
9.00	0. 00				0		0		0	0		9. 00
10.00	0. 00				0		0		0	0		10.00
200.00					0		0		0	657, 769		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/30/2017 11:41 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 458, 247 458, 247 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 655, 362 655, 362 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 206, 984 16, 825 3, 223, 809 4.00 00500 ADMINISTRATIVE & GENERAL 8. 303. 743 5 00 7 067 348 125, 805 183 890 926, 700 5 00 7.00 00700 OPERATION OF PLANT 1,029,484 10, 163 17,086 89, 244 1, 145, 977 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 6, 202 6, 202 8.00 00900 HOUSEKEEPI NG 413, 804 8, 773 63, 390 485, 967 9.00 9.00 C 17, 771 01000 DI ETARY 257, 258 198, 634 2, 202 38, 651 10 00 10 00 11.00 01100 CAFETERI A 287, 332 5, 512 C 91, 781 384, 625 11.00 01300 NURSING ADMINISTRATION 7, 551 47, 724 221, 721 13.00 166, 446 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 220 14.309 0 14, 529 694, 592 O 908, 069 15.00 01500 PHARMACY 22, 763 190, 714 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 399, 545 44, 459 1, 807, 134 30.00 0 363, 130 43.00 04300 NURSERY O 0 43 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 916, 891 36, 653 205, 258 178, 682 1, 337, 484 50.00 05100 RECOVERY ROOM 51.00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 Λ 52.00 05300 ANESTHESI OLOGY 6,593 53.00 -157 613 6, 137 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 250, 692 1, 877, 506 54.00 1, 426, 802 25.437 174, 575 56.00 05600 RADI OI SOTOPE 0 56,00 60.00 06000 LABORATORY 1, 188, 464 10,826 1, 948 0 1, 201, 238 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 66.00 06600 PHYSI CAL THERAPY 1,004,996 2,064 17,601 271, 731 1, 296, 392 66.00 06700 OCCUPATIONAL THERAPY 67.00 79,086 21, 288 100, 374 67.00 C06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 554, 691 13, 231 15, 714 162, 893 746, 529 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 433, 351 433, 351 71 00  $\cap$ 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 226, 327 0 226, 327 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 997, 391 73.00 1, 992, 145 0 5, 246 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 156, 230 0 1, 325 157, 555 90.01 09001 SENI OR CARE 227, 961 5, 315 0 41, 166 274, 442 90.01 91.00 09100 EMERGENCY 2, 388, 931 9, 403 19,503 209, 605 2, 627, 442 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92 00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 738, 229 7, 794 0 190, 140 936, 163 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 408, 551 0 72, 779 481, 330 116. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 27, 320, 496 655, 362 27, 235, 342 118. 00 385, 267 3, 211, 635 NONREI MBURSABLE COST CENTERS 2, 867 190. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2 867 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 43, 515 53, 937 0 12, 174 109, 626 192. 00 13, 840 194. 00 194.00 07950 FITNESS CENTER 0 13,840 194. 01 07951 FOUNDATI ON 1, 960 0 0 1, 241 194. 01 -719 194. 02 07952 NEW DIRECTION 0 0 194, 02 Ω 0 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 72,018 376 0 0 72, 394 194. 03 194. 04 07954 WELL CHILD CLINIC 0 0 0 194. 04 C 194. 05 07955 OCCUPATI ONAL HEALTH 857 194. 05 0 0 857 C 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 655, 362 3, 223, 809 202.00 TOTAL (sum lines 118-201) 27, 436, 167 458, 247 27, 436, 167 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016

754, 625

8.899

540, 541 202. 00

5/30/2017 11:41 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 8, 303, 743 5 00 5 00 7.00 00700 OPERATION OF PLANT 498, 289 1, 644, 266 7.00 00800 LAUNDRY & LINEN SERVICE 8,899 8.00 2,697 8.00 9.00 00900 HOUSEKEEPI NG 211, 306 57. 351 754.625 9.00 01000 DI ETARY 55, 246 540, 541 10.00 10.00 111,860 116, 177 0 11.00 01100 CAFETERI A 167, 241 36, 032 0 17, 134 11.00 0 13 00 01300 NURSING ADMINISTRATION 96, 408 49, 362 0 23, 473 0 13.00 01400 CENTRAL SERVICES & SUPPLY 6.317 14.00 14 00 93.546 0 44.484 0 15.00 01500 PHARMACY 394, 843 148, 812 0 70, 765 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 785.771 30.00 03000 ADULTS & PEDIATRICS 290, 644 1.523 138, 209 540, 541 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 113, 945 50.00 1, 157 50.00 581, 559 239, 617 0 05100 RECOVERY ROOM 51.00 0 C 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 C 0 52.00 05300 ANESTHESI OLOGY 53.00 2,867 4,006 C 1, 905 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 816, 370 166, 289 2, 234 79,075 0 54.00 56.00 05600 RADI OI SOTOPE C 0 56.00 60.00 06000 LABORATORY 522, 318 70, 775 0 33, 655 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 C06600 PHYSI CAL THERAPY 66,00 563, 692 13, 494 1, 311 6, 417 Λ 66.00 67.00 06700 OCCUPATI ONAL THERAPY 43,644 0 67.00 C 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 06900 ELECTROCARDI OLOGY 324, 603 0 0 69.00 69.00 86, 495 41, 131 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 188, 428 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 98, 411 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 868, 498 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 68, 507 0 0 90.00 0 90.01 09001 SENI OR CARE 119, 332 34, 743 0 16, 521 0 90.01 91.00 09100 EMERGENCY 1, 142, 458 2.673 29, 233 0 91.00 61.474 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 407, 059 50, 955 0 24, 231 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 209, 290 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 8, 231, 768 1, 519, 772 8,899 695, 424 540, 541 118. 00 NONREI MBURSABLE COST CENTERS 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 247 18, 742 8, 912 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 32, 319 0 0 192.00 194.00 07950 FITNESS CENTER 6,018 90, 477 0 43, 025 0 194.00 194. 01 07951 FOUNDATI ON 0 0 194 01 540 12, 815 6,094 194.02 07952 NEW DIRECTION 0 0 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 0 194. 03 31, 478 2, 460 1.170 194. 04 07954 WELL CHILD CLINIC 0 0 194. 04 C 0 0 194. 05 07955 OCCUPATI ONAL HEALTH 373 C 0 0 0 194 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 8, 303, 743 1, 644, 266

202.00

TOTAL (sum lines 118-201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

| Peri od: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared:

			10	12/31/2016	5/30/2017 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	I					
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY	, of ood					10.00
11. 00   01100   CAFETERI A	605, 032					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	16, 734		450.07/			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	C 12/	_	158, 876	1 500 074		14.00
15. 00 01500 PHARMACY	52, 136	1	8, 249	1, 582, 874	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	C	y U	0	U	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 O3000 ADULTS & PEDIATRICS	120 425	198, 641	14 022	( F10	0	20.00
30. 00   03000  ADULTS & PEDI ATRI CS 43. 00   04300  NURSERY	130, 435	1	14, 833	6, 510 0	0	30. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS		y U	U		0	43.00
50. 00 05000 OPERATI NG ROOM	64, 187	97, 756	27, 034	11, 360	0	50. 00
51. 00   05100   RECOVERY ROOM	04, 107	1	27,034	11, 300	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1	0		0	52. 00
53. 00   05300   ANESTHESI OLOGY			0	671	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	91, 473		2, 965	0,1	0	54. 00
56. 00   05600   RADI OI SOTOPE	71, 176		2, 700	o o	0	56. 00
60. 00 06000 LABORATORY			0	o o	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0	0	0	63.00
66. 00   06600   PHYSI CAL THERAPY		ol ol	2, 948	32, 675	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 683	ol	214	2, 375	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	1	0	-, -, 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	157, 407	ا	1, 789	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ol ol	58, 779	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	i c	ol ol	27, 781	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		ol	0	1, 529, 283	0	73. 00
OUTPATIENT SERVICE COST CENTERS		'	- "	, . ,		
90. 00 09000 CLI NI C	500	0	9	0	0	90. 00
90. 01   09001   SENI OR CARE	14, 361	o	41	0	0	90. 01
91. 00 09100 EMERGENCY	73, 116	111, 301	11, 723	O	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	C	0	1, 751	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	T	1				
113. 00 11300   INTEREST EXPENSE			507			113. 00
116. 00 11600 HOSPI CE	(05.000	1	527	1 500 074		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	605, 032	407, 698	158, 643	1, 582, 874	0	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	С	ol ol	0	ol	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES			179	0		190.00
194. 00 07950 FITNESS CENTER			1/7	0		194. 00
194. 01 07951 FOUNDATI ON			0	0		194. 00
194. 02 07952 NEW DI RECTI ON			0	0		194. 01
194. 03 07953 COMMUNITY & VOLUNTEER SERVICES			54	0		194. 02
194. 04 07954 WELL CHILD CLINIC			0	0		194. 04
194. 05 07955 OCCUPATI ONAL HEALTH		ا م	n	ol O		194. 05
200.00 Cross Foot Adjustments			J	٩	O	200.00
201.00 Negative Cost Centers	0	ا ا	n	n	n	201. 00
202.00 TOTAL (sum lines 118-201)	605, 032	407, 698	158, 876	1, 582, 874		202. 00
					_	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310

					To 12/31/2016	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/30/2017 11: 41 am
			Residents Cost	.o.ca.		
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	24 00		
	GENERAL SERVICE COST CENTERS	24. 00	25.00	26. 00		
	00100 CAP REL COSTS-BLDG & FLXT					1.00
	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	DO500 ADMINISTRATIVE & GENERAL					5. 00
1	00700 OPERATION OF PLANT					7. 00
	00800 LAUNDRY & LINEN SERVICE					8.00
1	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
1	D1100 CAFETERI A					11. 00
1	D1300 NURSI NG ADMI NI STRATI ON					13. 00
1	01400 CENTRAL SERVICES & SUPPLY					14. 00
- 1	D1500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
-	NPATIENT ROUTINE SERVICE COST CENTERS					
1	D3000 ADULTS & PEDIATRICS	3, 914, 241	0	3, 914, 24		30.00
	04300 NURSERY	0	0		0	43. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	2, 474, 099	0	2, 474, 09	o	50.00
1	D5100 RECOVERY ROOM	2, 4, 4, 0, 7	0		ó	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	o	Ö		o	52. 00
53.00	D5300 ANESTHESI OLOGY	16, 042	0	16, 04	2	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	3, 035, 912	0	3, 035, 91	2	54.00
1	D5600 RADI OI SOTOPE	0	0		0	56. 00
1	D6000 LABORATORY	1, 827, 986	0	1, 827, 98		60.00
	D6300 BLOOD STORING, PROCESSING & TRANS. D6600 PHYSICAL THERAPY	1 01/ 020	0		0	63.00
	06700 OCCUPATIONAL THERAPY	1, 916, 929 151, 290	0	1, 916, 92 151, 29		67. 00
	06800 SPEECH PATHOLOGY	131, 270	0		0	68.00
	06900 ELECTROCARDI OLOGY	1, 357, 954	Ö	1, 357, 95	-	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	680, 558	0	680, 55	8	71. 00
72.00	D7200 IMPL. DEV. CHARGED TO PATIENTS	352, 519	0	352, 51	9	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 395, 172	0	4, 395, 17	2	73. 00
	OUTPATIENT SERVICE COST CENTERS				_	
	09000   CLI NI C 09001   SENI OR   CARE	226, 571	0	226, 57		90.00
	D9100   SENTOR CARE	459, 440 4, 059, 420	0	459, 44 4, 059, 42		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,037,420	Ö	4, 037, 42		92. 00
	OTHER REIMBURSABLE COST CENTERS		<u> </u>			72.00
	10100 HOME HEALTH AGENCY	1, 420, 159	0	1, 420, 15	9	101. 00
-	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113. 00
1	11600 HOSPI CE	691, 147	0	691, 14		116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	26, 979, 439	0	26, 979, 43	9	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	31, 768	0	31, 76	8	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	142, 124	Ö	142, 12		192.00
	07950 FITNESS CENTER	153, 360	Ö	153, 36		194. 00
1	07951 FOUNDATION	20, 690	O	20, 69		194. 01
1	D7952 NEW DIRECTION	0	0		0	194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	107, 556	O	107, 55		194. 03
	07954 WELL CHILD CLINIC	0	0		0	194. 04
194. 05 ( 200. 00	07955 OCCUPATIONAL HEALTH	1, 230	0	1, 23	0	194. 05 200. 00
200.00	Cross Foot Adjustments Negative Cost Centers		0		0	200.00
201.00	TOTAL (sum lines 118-201)	27, 436, 167	0	27, 436, 16	-	202. 00
	1.1 (66 1.1.65 1.16 261)	2.7.1007.107	٩	2., .55, 10	* [	1232. 00

Provider CCN: 15-1310

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared:

COST Center Description					To	12/31/2016	Date/Time Pre 5/30/2017 11:	
Acst gned New   Capit tal   Rel atted Costs   1.00   2.00   2A   4.00   1.00   2.00   2A   4.00   1.00   2.00   2A   4.00   1.00   2.00   2D   2A   4.00   1.00   2.00   2D   2D   2D   2D   2D   2D   2D				CAPITAL RELATED COSTS			3/30/2017 11.	41 4111
Acst gned New   Capit tal   Rel atted Costs   1.00   2.00   2A   4.00   1.00   2.00   2A   4.00   1.00   2.00   2A   4.00   1.00   2.00   2D   2A   4.00   1.00   2.00   2D   2D   2D   2D   2D   2D   2D								
		Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
Belated Costs								
SENERAL SERVICE COST CENTERS   1.00   2.00   2.00   2.00   2.00   1.00							DEFARTMENT	
1.00   00100   CAP PET LOSTS-BLIDG & FIXT				1.00	2.00	2A	4. 00	
2.00			_					
1.00   00000   EMPLOYEE BENEFITS DEPARTMENT   0   16,825   0   16,825   4,306   5.00   000000								
5.00   00500   DAMIN INSTRATIVE & CERREAL   619, 828   125, 805   183, 890   229, 523   4, 835   5, 0.0     8.00   00600   LAURDRY & L.I.INEN SERVICE   0   0, 0   6, 202   6, 202   0, 8, 0.0     8.00   00600   HUSEKEEP IN 18   0   0, 17, 771   0   0, 200   0, 0     8.00   00600   HUSEKEEP IN 18   0   0, 17, 771   0   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   0, 17, 771   1, 10, 10, 10, 10, 10, 10, 10, 10, 10,			0	1/ 005	0	14 005	1/ 025	1
0.000   00700   OPERATION OF PLANT   0   10,163   17,086   27,249   466   7,09   0   0   0   0   0   0   0   0   0			610 828					1
8.00   00800   LANDREY & LINEN SERVICE   0   0   6,202   6,202   0,8,00								
9.00   000000   HOUSEKEPING   0   8, 773   0   8, 773   202   19, 973   202   10, 00   11.00   01000   017000   017000   017000   0170			_					1
10. 00   010000   015000   0			0	8, 773				
13. 00   01300   MURSI NO ADMINI STRATION   0   7, 551   0   7, 551   3.00   14. 309   0   14. 00   10. 00   10. 00   10. 00   0   0   0   0   0   0   0   15. 00   16. 00   10. 00   10. 00   0   0   0   0   0   0   0   0	10.00	01000 DI ETARY	0	17, 771	2, 202	19, 973	202	10. 00
14. 00   01400   CENTRAL SERVICES & SUPPLY   0   14. 309   0   14. 309   0   14. 00     16. 00   01600   MEDICAL RECORDS & LIBRARY   0   0   0   0   0   0   0     17. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   0   0   0   0   0   0     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17. 00   17. 00     18. 00   17. 00   17. 00   17.	11.00		0	5, 512	0	5, 512	479	11. 00
15. 00   OTSOO   PHARMACY   0   22, 763   0   22, 762   995   15. 00   16			0		0		249	1
10.00   01600   01610   0160   0   0   0   0   0   0   0   0   0			0					1
IMPATI ENT ROUTINE SERVICE COST CENTERS   0   44, 459   0   44, 459   30, 00   430, 00   430, 00   430, 00   44, 459   0   44, 459   30, 00   43, 00   43, 00   43, 00   430, 00   44, 459   0   44, 459   30, 00   43, 0								1
30.00   03000   ADULTS & PEDI ATRI CS   0   44, 459   0   44, 459   1, 895   30, 00   AU, 00   0   0   0   0   0   0   0   0   0	16.00		0	0	0	U	0	16.00
A3. 00   A300   NURSERY	30 00		0	44 450	0	44 450	1 805	30 00
ANCILLARY SERVICE COST CENTERS			1		- 1		· ·	1
50.00   0500	10.00				<u> </u>	<u> </u>		10.00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   52.00	50.00		0	36, 653	205, 258	241, 911	933	50.00
53.00   05300   ANESTHESI OLOGY   0   613   6,137   6,750   0   53.00	51.00	05100 RECOVERY ROOM	0	0	0	O	0	51.00
54.00   05400   RADIO LOGY-DI AGNOSTI C   0   25,437   174,575   200,012   1,308   54.00			0	0	0	0	0	1
56. 00   05.00   05.00   05.00   0   0   0   0   0   0   0   0   0			0				-	1
60. 00   06000   LABORATORY   0   10,826   1,948   12,774   0   60. 00   63. 00   06300   BLODD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   2,064   17,601   19,665   1,418   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   111   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   13,231   15,714   28,945   850   69. 00   69. 00   06900   ELECTROCARDI OLOGY   0   13,231   15,714   28,945   850   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   73. 00   0UTPATI ENT SERVICE COST CENTERS   0   0   0   0   0   0   7. 790   90. 01   09000   ELINIC OST CENTERS   0   0   0   0   5, 246   0   7. 90. 01   91. 00   09100   EMERGENCY   0   9, 403   19, 503   28, 906   1, 094   91. 00   92. 00   09200   DESERVATION BEDS (NON-DISTINCT PART   0   0   7, 794   99. 20   00   09200   DESERVATION BEDS (NON-DISTINCT PART   0   0   7, 794   99. 20   00   0100   HOME HEALTH AGENCY   0   7, 794   99. 20   01100   101000   HOME HEALTH AGENCY   0   7, 794   99. 20   01100   101000   HOME HEALTH AGENCY   0   0   0   0   0   380   116. 00   0110   100   001000   GFT, FLOWER, COFFEE SHOP & CANTEEN   0   2, 867   0   2, 867   0   10, 60   118. 00   0110   100   001000   GFT, FLOWER, COFFEE SHOP & CANTEEN   0   13, 840   0   13, 840   0   194. 00   0190   109000   GFT, FLOWER, COFFEE SHOP & CANTEEN   0   13, 840   0   14, 90   0   0   0   0   0   0   0   0   0			0		174, 575	· · · · · · · · · · · · · · · · · · ·		1
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   63.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   0   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENT   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   5, 246   5, 246   0   73.00   72.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   5, 246   5, 246   0   73.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   5, 246   5, 246   0   73.00   74.00   07400   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   7, 20.00   75.00   07400   DRUGS CHARGED TO PATI ENTS   0   0   0   5, 246   5, 246   0   73.00   76.00   09000   CLINIC COST CENTERS   0   0   0   0   0   7, 90.00   77.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   7, 90.00   78.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   09000   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   79.00   0900			0	_	1 040	9		1
66.00   06600   PHYSICAL THERAPY   0   2,064   17,601   19,665   1,418   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   111   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   13,231   15,714   28,945   850   69.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   5,246   5,246   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   5,246   5,246   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   5,246   5,246   0   73.00   09000   CLINIC   0   0   0   0   0   7,700   74.00   09001   SENIOR CARE   0   0   0   0   0   7,700   75.00   09001   SENIOR CARE   0   0   0   5,315   215   75.01   09001   SENIOR CARE   0   0   0   5,315   215   75.01   09001   SENIOR CARE   0   0   0   0   0   0   75.02   09200   09SERVATION BEDS (NON-DISTINCT PART   0   0   7,794   992   75.00   09100   MERESIC COST CENTERS   0   0   0   7,794   992   75.00   09100			0	10, 826	1, 948	12, 774	_	
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   111   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   5,246   5,246   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   5,246   5,246   0   73. 00   74. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7,300   75. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7,300   76. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7,300   77. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7,300   78. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   7,300   79. 00   09000   CLINI C   0   0   0   0   0   0   0   7,300   79. 00   09000   CLINI C   0   0   0   0   0   0   0   0   7,300   79. 00   09000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   79. 00   09000   CLINI C   0   0   0   0   0   0   0   0   0			0	2 064	17 601	19 665	-	
68.00   0.6800   SPEECH PATHOLOGY   0   0   0   0   0   0   68.00   69.00   0.6900   ELECTROCARDI OLOGY   0   13, 231   15,714   28,945   850   69.00   71.00   0.7100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   72.00   0.7200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   0.7300   DRUGS CHARGED TO PATIENTS   0   0   0   5, 246   5, 246   0   73.00   0.7300   DRUGS CHARGED TO PATIENTS   0   0   0   5, 246   5, 246   0   74.00   0.7300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   75.00   0.7300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   76.01   0.09001   SENIOR CARE   0   0   0   0   0   0   77.00   0.01   0.09001   SENIOR CARE   0   0   0   0   0   0   79.00   0.01   0.09001   SENIOR CARE   0   0   0   0   0   0   79.00   0.09001   0.00   0.00   0   0   0   0   79.00   0.00   0.00   0.00   0   0   0   79.00   0.00   0.00   0.00   0.00   0   0			0		0			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00  73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 5, 246 5, 246 0 73. 00  0000 07300 DRUGS CHARGED TO PATIENTS 0 0 0 5, 246 5, 246 0 73. 00  0000 09000 CLINIC 0 0 0 0 5, 345 0 5, 3			0	0	0	O		1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   5,246   5,246   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   5,246   5,246   0   73. 00   0UTPATIENT SERVICE COST CENTERS	69.00	06900 ELECTROCARDI OLOGY	0	13, 231	15, 714	28, 945	850	69. 00
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   5,246   5,246   0   73.00   0000   CLI NI C   0   0   0   0   0   0   0   0   0				0	0	0	0	1
90. 00   00000   CLINIC   0 0 0 0 0 0 7 90. 00				_	0	0		1
90. 00   09000   CLINIC   0   0   0   0   0   0   7   90. 00   90. 01   09001   SENI OR CARE   0   5, 315   0   5, 315   215   90. 01   91. 00   09100   EMERGENCY   0   9, 403   19, 503   28, 906   1, 094   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0   9, 403   19, 503   28, 906   1, 094   92. 00   OTHER REI MBURSABLE COST CENTERS   0   7, 794   0   7, 794   992   101. 00   SPECI AL PURPOSE COST CENTERS   0   0   0   0   380   116. 00   11600   HOSPI CE   0   0   0   0   380   118. 00   SUBTOTALS (SUM OF LINES 1-117)   619, 828   385, 267   655, 362   1, 660, 457   16, 761   118. 00   NONREI MBURSABLE COST CENTERS   113. 00   192. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   2, 867   0   190. 00   194. 00   07950   FI TNESS CENTER   0   13, 840   0   13, 840   0   194. 00   194. 01   07951   FOUNDATI ON   0   1, 960   0   1, 960   0   194. 01   194. 02   07952   NEW DI RECTI ON   0   0   0   0   0   0   194. 04   07954   WELL CHILD CLINIC   0   0   0   0   0   0   194. 05   07955   OCCUPATI ONAL HEALTH   0   0   0   0   0   0   200. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0   200. 00   0   0	73. 00		0	0	5, 246	5, 246	0	73. 00
90. 01   09001   SENI OR CARE   0   5, 315   0   5, 315   215   90. 01   91. 00   09100   EMERGENCY   0   9, 403   19, 503   28, 906   1, 094   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   7, 794   91. 00   92. 00   OTHER REI MBURSABLE COST CENTERS   0   113. 00   11300   INTEREST EXPENSE   0   0   0   0   0   380   116. 00   118. 00   11600   HOSPI CE   0   0   0   0   0   0   380   116. 00   118. 00   SUBTOTALS (SUM OF LI NES 1-117)   619, 828   385, 267   655, 362   1, 660, 457   16, 761   118. 00   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   2, 867   0   22, 867   0   190. 00   194. 00   07950   FI TNESS CENTER   0   13, 840   0   13, 840   0   194. 00   194. 01   07951   FOUNDATI ON   0   1, 960   0   1, 960   0   194. 01   194. 02   07952   NEW DI RECTI ON   0   0   0   0   0   0   194. 04   07954   WELL CHILD CLI NI C   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   376   0   376   0   194. 03   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   376   0   376   0   194. 03   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   0   0   194. 05   07955   OCCUMANI TY & VOLUNTEER SERVI CES   0   0   0   0   0   0   0   0   0	00 00			0		ام	7	00.00
91. 00					0	-1	215	1
92. 00			1		19 503			
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   0   7,794   0   7,794   992   101.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11600   HOSPI CE   0   0   0   0   0   380   116.00   118.00   SUBTOTALS (SUM OF LINES 1-117)   619,828   385,267   655,362   1,660,457   16,761   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   2,867   0   2,867   0   190.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   53,937   0   53,937   64   192.00   194.00   107951   FOUNDATI ON   0   1,960   0   1,960   0   194.00   194.				,, 100	. ,, 555		., ., .	
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   0 0 0 0 0 0 0 380   116.00   1160								
113. 00	101.00		0	7, 794	0	7, 794	992	101. 00
116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1-117)   619, 828   385, 267   655, 362   1, 660, 457   16, 761   118. 00   NONREI MBURSABLE COST CENTERS								
118. 00		· ·						1
NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   2,867   0   190.00   192.00			(10,000	0	(55.27.2	-1		
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   2,867   0   2,867   0   190. 00   192. 00   19200   19200   194. 01   190. 00   194. 00   194. 00   194. 01   194. 01   194. 01   194. 01   194. 02   194. 02   194. 03   194. 04   194. 04   194. 04   194. 04   194. 05   194. 05   194. 05   194. 05   194. 00   194. 05   194. 0	118.00		619, 828	385, 267	655, 362	1, 660, 457	16, /61	]118.00
192. 00   1920	190 00		1 0	2 867	0	2 867	0	190 00
194. 00     07950     FI TNESS CENTER     0     13,840     0     13,840     0     194.00       194. 01     07951     FOUNDATION     0     1,960     0     1,960     0     194.01       194. 02     07952     NEW DI RECTION     0     0     0     0     0     0     194.02       194. 03     07954     WELL CHILD CLINIC     0     0     0     0     0     194.03       194. 05     07955     OCCUPATIONAL HEALTH     0     0     0     0     0     194.05       200. 00     Cross Foot Adjustments     0     0     0     0     0     200.00       201. 00     Negative Cost Centers     0     0     0     0     0     0		i i	0		0			1
194. 01   07951   FOUNDATION   0   1,960   0   1,960   0   194. 01     194. 02   07952   NEW DIRECTION   0   0   0   0   0     194. 03   07953   COMMUNITY & VOLUNTEER SERVICES   0   376   0   376   0     194. 04   07954   WELL CHILD CLINIC   0   0   0   0     194. 05   07955   OCCUPATIONAL HEALTH   0   0   0   0     200. 00   Cross Foot Adjustments   0   0   0     201. 00   Negative Cost Centers   0   0   0     201. 00   0   0   201. 00     201. 00   0   0   0     201. 00   0   0   0     201. 00   0   0   0     201. 00   0   0   0     201. 00   0   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00   0     201. 00     201. 00   0     201. 00			_					
194. 03     07953     COMMUNITY & VOLUNTEER SERVICES     0     376     0     194. 03       194. 04     07954     WELL CHILD CLINIC     0     0     0     0     0     194. 04       194. 05     07955     OCCUPATI ONAL HEALTH     0     0     0     0     0     194. 05       200. 00     Cross Foot Adjustments     0     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     0     201. 00			0			ı		
194. 04     07954     WELL CHILD CLINIC     0     0     0     0     194. 04       194. 05     07955     OCCUPATI ONAL HEALTH     0     0     0     0     0     194. 05       200. 00     Cross Foot Adjustments     0     0     0     0     0     0     0       201. 00     Negative Cost Centers     0     0     0     0     0     0     201. 00	194. 02	2 07952 NEW DIRECTION	0	0	0	o	0	194. 02
194. 05 07955     OCCUPATI ONAL HEALTH     0     0     0     0     194. 05       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     0     201. 00			0	376	0	376		
200.00       Cross Foot Adjustments       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00			0	0	0	0		
201. 00   Negative Cost Centers   0   0   0   201. 00			0	0	0	0	0	1
		1		_		0	0	
202.00    1017.6 (30iii 11103 110 201)   017,020  400,247  000,002  1,700,407  10,020 202.00		9	61Q Q2Q	U 458 247	655 362	0 1 733 437		
	202.00	1.01/12 (30/11/11/03/10/03/11/03/11/03/11/03/11/03/11/03/11/03/10/100/10	017,020	1 750, 247	555, 552	1, 755, 757	10, 023	1-02.00

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

				11	0 12/31/2016	Date/lime Pre 5/30/2017 11:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	TI GIII
	occi conten becomparen	& GENERAL	PLANT	LINEN SERVICE	HOUGENEEL ING	51217111	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	934, 359					5. 00
7.00	00700 OPERATION OF PLANT	56, 069	83, 784				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	303	0	-,			8. 00
9.00	00900 HOUSEKEEPI NG	23, 777	2, 922	1	35, 804		9. 00
10.00	01000 DI ETARY	12, 587	5, 920		2, 621	41, 303	
11. 00	01100 CAFETERI A	18, 819	1, 836		813	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	10, 848	2, 515		1, 114	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	711	4, 767		2, 111	0	14. 00
15. 00	01500 PHARMACY	44, 429	7, 583		3, 358	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1	1		
30.00	03000 ADULTS & PEDI ATRI CS	88, 418			6, 557	41, 303	1
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	/= +00	40.040	1			
50.00	05000 OPERATI NG ROOM	65, 439	12, 210		5, 406	0	
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	323	204		90	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C   05600  RADI OI SOTOPE	91, 861	8, 473	1		0	54.00
56.00		F0 773	0		1 507	0	
60.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	58, 773	3, 606		1, 597	0	60.00
63. 00 66. 00	06600 PHYSI CAL THERAPY	42 420	0 688		304	0	63. 00 66. 00
67.00	06700 OCCUPATIONAL THERAPY	63, 429 4, 911	088		304	0	67.00
68. 00	06800 SPEECH PATHOLOGY	4, 711	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	36, 525	4, 407		1, 951	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 203	4,407		1, 931	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 074	Ö		0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	97, 726	Ö		-1	0	
70.00	OUTPATIENT SERVICE COST CENTERS	77,720			٥		70.00
90.00	09000 CLINI C	7, 709	0	0	0	0	90. 00
90. 01	09001 SENI OR CARE	13, 428			784	0	90. 01
91. 00	09100 EMERGENCY	128, 544	3, 132		1, 387	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	120,011	-,		.,	_	92.00
	OTHER REIMBURSABLE COST CENTERS	'					
101.00	10100 HOME HEALTH AGENCY	45, 804	2, 596	0	1, 150	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	23, 550	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	926, 260	77, 441	6, 505	32, 995	41, 303	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	140	955	0	423	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 637	0		0		192. 00
	07950 FITNESS CENTER	677	4, 610	0	2/011		194. 00
	07951 FOUNDATI ON	61	653		289		194. 01
	2 07952 NEW DIRECTION	0	0		0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	3, 542	125		56		194. 03
	07954 WELL CHILD CLINIC	0	0		0		194. 04
	07955 OCCUPATI ONAL HEALTH	42	0	0	0	0	194. 05
200.00	3						200. 00
201.00		0	0		0		201. 00
202.00	TOTAL (sum lines 118-201)	934, 359	83, 784	6, 505	35, 804	41, 303	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1310

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2016	Part II
To 12/31/2016	Date/Time Prepared:
5/30/2017	11: 41 am

					12/31/2010	5/30/2017 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	27, 459					11. 00
13. 00	01300 NURSING ADMINISTRATION	759	1				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	, , ,	25, 050	21, 898			14. 00
15. 00	01500 PHARMACY	2, 366	ام	1, 137	82, 631		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2,300		1, 137	02, 031	0	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	5, 920	11, 224	2, 044	340	0	30. 00
43. 00	04300 NURSERY	5, 920	i i	2, 044	0	0	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	l d	U	υ	U	43.00
EO 00	05000 OPERATING ROOM	2 012	E E22	2 724	593	0	FO 00
50. 00 51. 00		2, 913	5, 523	3, 726	593		50.00
	05100 RECOVERY ROOM	0	٥	J	U	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	35	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 151	0	409	0	0	54.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	406	1, 706	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	213	0	30	124	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	7, 144	0	247	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8, 100	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 829	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	79, 833	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	23	0	1	0	0	90.00
90. 01	09001 SENI OR CARE	652	0	6	0	0	90. 01
91.00	09100 EMERGENCY	3, 318	6, 289	1, 616	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	241	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	73	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	27, 459	23, 036	21, 865	82, 631	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	o	25	0	0	192. 00
	07950 FITNESS CENTER	0	ol	0	0		194. 00
	07951 FOUNDATI ON	0	l ol	0	o		194. 01
	2 07952 NEW DIRECTION	0	o	0	o		194. 02
	3 07953 COMMUNITY & VOLUNTEER SERVICES	0	o	8	0		194. 03
	107954 WELL CHILD CLINIC	0	اً م	0	n		194. 04
	07955 OCCUPATI ONAL HEALTH	0	المال	n	ol O		194. 05
200.00					٩	O	200. 00
201.00	1 1	_	۸	O	م	Λ	201. 00
201.00		27, 459	23, 036	21, 898	82, 631		202.00
202.00	101AL (30111 111103 110-201)	27,437	25, 030	21,090	02, 031	U	1202.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310

					Γο 12/31/2016	Date/Time Prepared: 5/30/2017 11:41 am
	Cost Center Description	Subtotal	Intern &	Total		573072017 11.41 alli
			Residents Cost			
			& Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00	_	
	GENERAL SERVICE COST CENTERS	1	•		*	
	00100 CAP REL COSTS-BLDG & FLXT					1. 00
	00200 CAP REL COSTS-MVBLE EQUI P					2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
	00700 OPERATION OF PLANT					7. 00
	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9. 00
10. 00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
	01500 PHARMACY					15.00
	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	218, 085	0	218, 085		30.00
	04300 NURSERY	0	0	(	0	43. 00
	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	339, 500	ol	339, 500	1	50. 00
	05100 RECOVERY ROOM	339, 500	0	·		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	o			52.00
53.00	05300 ANESTHESI OLOGY	7, 402	О	7, 402	2	53.00
	05400 RADI OLOGY-DI AGNOSTI C	311, 599	0	311, 599		54. 00
56.00	05600 RADI OI SOTOPE	0	0	7/ 75/	-	56. 00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	76, 750	0	76, 750		60. 00 63. 00
66. 00	06600 PHYSI CAL THERAPY	88, 574	0	88, 574		66.00
	06700 OCCUPATI ONAL THERAPY	5, 389	o	5, 389		67. 00
68.00	06800 SPEECH PATHOLOGY	0	o	(	o l	68. 00
	06900 ELECTROCARDI OLOGY	80, 069	0	80, 069		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 303	0	29, 303		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	14, 903 182, 805	0	14, 903 182, 805		72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	102,003	<u> </u>	102, 003	7	73.00
90.00	09000 CLI NI C	7, 740	0	7, 740	ס	90.00
	09001 SENI OR CARE	22, 170	O	22, 170	o l	90. 01
	09100 EMERGENCY	176, 240	0	176, 240	D	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY	58, 577	ol	58, 57	7	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	30, 377	<u> </u>	30, 37	/	101:00
113.00	11300   NTEREST EXPENSE					113. 00
116. 00	11600 HOSPI CE	24, 003	O	24, 003	3	116. 00
118. 00		1, 643, 109	0	1, 643, 109	9	118. 00
	NONREI MBURSABLE COST CENTERS	4 205	٥	4 201	-1	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	4, 385 57, 663	0	4, 385 57, 663		190. 00 192. 00
	07950 FITNESS CENTER	21, 168	0	21, 168		194. 00
194. 01	07951 FOUNDATI ON	2, 963	Ō	2, 963		194. 01
	07952 NEW DIRECTION	0	o		o l	194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	4, 107	0	4, 10		194. 03
	07954 WELL CHILD CLINIC	0	0	() A1		194. 04
200.00	07955 OCCUPATIONAL HEALTH Cross Foot Adjustments	42	0	42		194. 05 200. 00
201.00			o			201. 00
202.00	9	1, 733, 437	o	1, 733, 437	7	202. 00

	•	PARKVIEW WADASH				u or Form CW3-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CO	IN: 15-1310   F	Peri od:	Worksheet B-1	
					From 01/01/2016 o 12/31/2016	Date/Time Pre	narod:
				'	0 12/31/2010	5/30/2017 11:	41 am
		CAPLTAL REI	LATED COSTS			070072017 11.	11 (4111
		07.11.7.12.1.12.1	271125 00010				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS	incconci i i ati on	& GENERAL	
		(SQUARE TELT)	(DOLLAR VALUE)				
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	0.00	SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 CAP REL COSTS-BLDG & FIXT	127, 872					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		799, 536				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 695	0	10, 521, 828	3		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	35, 105	224, 344	3, 024, 547		19, 097, 125	5.00
7. 00	00700 OPERATION OF PLANT	2, 836		291, 273			1
8. 00	00800 LAUNDRY & LINEN SERVICE	2,000					1
9. 00	00900 HOUSEKEEPING	1			-		1
		2, 448		206, 891		485, 967	1
10.00	01000 DI ETARY	4, 959		126, 150			1
11. 00	01100 CAFETERI A	1, 538		299, 553		384, 625	1
13.00	01300 NURSING ADMINISTRATION	2, 107	0	155, 760	0	221, 721	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 993	0	(	0	14, 529	14.00
15.00	01500 PHARMACY	6, 352	0	622, 450	0	908, 069	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	o	l	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00	03000 ADULTS & PEDIATRICS	12, 406	0	1, 185, 182	2 0	1, 807, 134	30.00
43. 00	04300 NURSERY	12, 400					1
43.00			l O		, 0		43.00
FO 00	ANCILLARY SERVICE COST CENTERS	10,000	250 414	F00 100	V 0	1 227 404	
50. 00	05000 OPERATING ROOM	10, 228	250, 414	583, 180	0		•
51. 00	05100 RECOVERY ROOM	0	0	(	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
53.00	05300 ANESTHESI OLOGY	171	7, 487	(	0	6, 593	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 098	212, 980	818, 206	0	1, 877, 506	54.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	1
60.00	06000 LABORATORY	3, 021	2, 376	ď	0	1, 201, 238	•
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0,021	2,0.0		n n	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	576	21, 473	886, 875		1, 296, 392	•
		370	21,4/3				1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	69, 478	0	100, 374	
68. 00	06800 SPEECH PATHOLOGY	0	0	(	0	0	
69. 00	06900 ELECTROCARDI OLOGY	3, 692	19, 171	531, 649	9 0	746, 529	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	433, 351	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	226, 327	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 400	l	0	1, 997, 391	73.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			"		1
90.00	09000 CLI NI C	0	0	4, 324	1 0	157, 555	90.00
90. 01	09001 SENI OR CARE	1, 483					1
91. 00	09100 EMERGENCY	1					
		2, 624	23, 193	004, 100		2,027,442	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2, 175	0	620, 577	0	936, 163	]101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0	237, 535	0	481, 330	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	107, 507	799, 536				•
	NONREI MBURSABLE COST CENTERS	,	,	10, 102, 111	., ., ., ., ., ., ., ., ., ., ., ., ., .	, , , , , , , , , , , , , , , , , , , ,	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	(	) 0	2 867	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	15, 051		39, 735	-35, 299		192. 00
							•
	07950 FITNESS CENTER	3, 862		(	1		194. 00
	07951 FOUNDATI ON	547		(	0		194. 01
	07952 NEW DIRECTION	0	0	(	0	0	194. 02
194. 03	07953 COMMUNITY & VOLUNTEER SERVICES	105	0	(	0	72, 394	194. 03
194. 04	07954 WELL CHILD CLINIC	0	0	C	0	0	194. 04
194.05	07955 OCCUPATI ONAL HEALTH	0	0	1	0	857	194. 05
200.00							200.00
201.00							201. 00
		4E0 047	455 343	2 222 000		0 202 742	1
202. 00		458, 247	655, 362	3, 223, 809	Ί	8, 303, 743	202.00
202 00	Part I)	2 502/20	0.010470	0.304303		0 424017	202 00
203.00		3. 583638	0. 819678			0. 434816	•
204.00	71			16, 825		934, 359	204. 00
	Part II)	1					
205.00	· · · · · · · · · · · · · · · · · · ·			0. 001599	9	0. 048927	205. 00

			ARKVIEW WABASH		011 45 4040		u of Form CMS-	
COSTA	LLOCA	TION - STATISTICAL BASIS		Provi der Co	1	Period: From 01/01/2016	Worksheet B-1	
						Го 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
			7.00	LAUNDR)	0.00	10.00	11 00	
	GENER	AL SERVICE COST CENTERS	7.00	8. 00	9. 00	10.00	11. 00	
1. 00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500	ADMINISTRATIVE & GENERAL						5. 00
7.00		OPERATION OF PLANT	70, 185					7. 00
8.00		LAUNDRY & LINEN SERVICE	0	10, 000				8. 00
9.00	1	HOUSEKEEPI NG	2, 448	1	67, 73	1		9.00
10. 00 11. 00	1	DI ETARY CAFETERI A	4, 959 1, 538	0	4, 959 1, 538		9, 690	10.00
13. 00	1	NURSING ADMINISTRATION	2, 107	0	2, 10	I I	9, 690 268	1
14. 00		CENTRAL SERVICES & SUPPLY	3, 993	0	3, 99:	I I	0	1
		PHARMACY	6, 352	0	6, 352		835	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	(	0	0	16. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDI ATRI CS	12, 406	1, 711	12, 40		2, 089	
43. 00		NURSERY	0	0		0	0	43. 00
50. 00	05000	LARY SERVICE COST CENTERS  OPERATING ROOM	10, 228	1, 300	10, 228	3 ol	1, 028	50.00
51. 00		RECOVERY ROOM	10, 220	1, 300			1,020	1
52. 00		DELIVERY ROOM & LABOR ROOM	0	Ö			0	1
53.00		ANESTHESI OLOGY	171	0	17 <sup>-</sup>	1 0	0	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	7, 098	2, 510	7, 098	3 0	1, 465	54.00
56.00		RADI OI SOTOPE	0	0	•	0	0	
60.00	1	LABORATORY	3, 021	0	3, 02		0	
63. 00		BLOOD STORING, PROCESSING & TRANS.	0	0	(	-	0	00.00
66. 00	1	PHYSI CAL THERAPY	576	1, 473	1		0	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	)		75 0	1
69. 00		ELECTROCARDI OLOGY	3, 692	0	3, 692		2, 521	
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	1
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
		TIENT SERVICE COST CENTERS	1 -		Т	_1 _1		
		CLINIC SENIOR CARE	1 403	0			8	
90. 01 91. 00		EMERGENCY	1, 483 2, 624	3, 005	1, 483 2, 624		230 1, 171	1
	1	OBSERVATION BEDS (NON-DISTINCT PART	2,024	3,003	2, 02.	1	1, 171	92.00
72.00		REI MBURSABLE COST CENTERS			I.			72.00
101.00		HOME HEALTH AGENCY	2, 175	0	2, 17!	5 0	0	101. 00
		AL PURPOSE COST CENTERS			,			
		I NTEREST EXPENSE						113. 00
		HOSPICE	0	_	•	0 10 924		116.00
118. 00		SUBTOTALS (SUM OF LINES 1-117)  IMBURSABLE COST CENTERS	64, 871	10, 000	02, 42.	3 19, 826	9, 090	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	800	ol ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
		FITNESS CENTER	3, 862	0	3, 862	2 0		194. 00
		FOUNDATI ON	547	0	547	7 0	0	194. 01
		NEW DIRECTION	0	0	(			194. 02
		COMMUNITY & VOLUNTEER SERVICES	105	0	105			194. 03
		WELL CHILD CLINIC OCCUPATIONAL HEALTH	0	0	)			194. 04 194. 05
200.00		Cross Foot Adjustments		0	1	٩	U	200.00
201.00		Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	1, 644, 266	8, 899	754, 62!	540, 541	605, 032	
		Part I)						
203.00	1	Unit cost multiplier (Wkst. B, Part I)	23. 427598			I I	62. 438803	
204. 00	)	Cost to be allocated (per Wkst. B,	83, 784	6, 505	35, 804	41, 303	27, 459	204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	1. 193759	0. 650500	0. 528574	2. 083274	2. 833746	205 00
200.00			1. 173737	5. 030300	0. 32037	2.003274	2. 033740	200.00
				•		. '		•

<u>Heal</u> th	Financial Systems F	PARKVIEW WABASH F	IOSPI TAL, I NC.		In Lie	u of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-1310	Period: From 01/01/2016	Worksheet B-1
					To 12/31/2016	
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HR) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REV)	5/30/2017 11: 41 am
	GENERAL SERVICE COST CENTERS	10.00		10.00	10.00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 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	89, 671 0 0	1, 294, 336 67, 201 0	174, 58	7 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00	03000 ADULTS & PEDIATRICS	43, 690	120, 839	718	8 0	30.00
	04300 NURSERY	0	0		0	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	21, 501	220, 242	1, 25	3 0	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	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OLOGY-DI AGNOSTI C 06600 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 DRUGS CHARGED TO PATI ENTS 00TPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0	0 0 24, 155 0 0 24, 018 1, 745 0 14, 573 478, 858 226, 327	3, 60- 26: ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 56. 00 63. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
	09000 CLINIC	0	76		0	90.00
91. 00 92. 00	09001 SENIOR CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 480	334 95, 509		0 0	90. 01 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY	0	14, 264		0 0	101.00
	SPECIAL PURPOSE COST CENTERS					
116. 00 118. 00	11300   INTEREST EXPENSE 11600   HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 89, 671	4, 295 1, 292, 436		0 7 0	113. 00 116. 00 118. 00
190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 FITNESS CENTER 07951 FOUNDATION 07952 NEW DIRECTION 07953 COMMUNITY & VOLUNTEER SERVICES 07954 WELL CHILD CLINIC	0 0 0 0 0 0	0 1, 456 0 0 0 444 0			192. 00 194. 00 194. 01 194. 02 194. 03 194. 04
194. 05 200. 00 201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	407, 698	0 158, 876	1, 582, 87	4 0	194. 05 200. 00 201. 00 202. 00
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	4. 546598 23, 036	0. 122747 21, 898	9. 06639 <sup>.</sup> 82, 63 <sup>.</sup>		203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 256895	0. 016918	0. 47329	0. 000000	205. 00

Health Financial Systems Pa	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepar 5/30/2017 11:41		
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						5/30/2017 11:	41 alli
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	,				
		26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 914, 241		3, 914, 241	0	0	30.00
43. 00	04300 NURSERY	0		0, ,		0	
	ANCILLARY SERVICE COST CENTERS	-1			-	_	1
50.00	05000 OPERATING ROOM	2, 474, 099		2, 474, 099	0	0	50.00
51. 00	05100 RECOVERY ROOM	_,,		_,,	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			Ċ	0	0	
53. 00	05300 ANESTHESI OLOGY	16, 042		16, 042	0	Ö	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 035, 912		3, 035, 912		Ö	1
56. 00	05600 RADI OI SOTOPE	0,000,712		0,000,712	0	0	
60.00	06000 LABORATORY	1, 827, 986		1, 827, 986	0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1,027,700		1, 027, 700	0	0	1
66. 00	06600 PHYSI CAL THERAPY	1, 916, 929	0	1, 916, 929	0	. 0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	151, 290	0	151, 290		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	131, 270	0	131, 270	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 357, 954	U	1, 357, 954	0	0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	680, 558		680, 558		0	1
71.00	07200 I MPL. DEV. CHARGED TO PATTENTS	352, 519		352, 519		0	
73.00	07300 DRUGS CHARGED TO PATIENTS			•		0	1
73.00	OUTPATIENT SERVICE COST CENTERS	4, 395, 172		4, 395, 172	l U		/3.00
00.00	09000 CLINIC	00/ 574		00/ 574			
90.00		226, 571		226, 571		0	
90. 01	09001 SENI OR CARE	459, 440		459, 440		0	
91.00	09100 EMERGENCY	4, 059, 420		4, 059, 420		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	868, 560		868, 560		0	92. 00
	OTHER REIMBURSABLE COST CENTERS				1		4
101.00	10100 HOME HEALTH AGENCY	1, 420, 159		1, 420, 159		0	101. 00
	SPECIAL PURPOSE COST CENTERS	, ,					1
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	691, 147		691, 147			116. 00
200.00		27, 847, 999	0	27, 847, 999	0		200. 00
201.00	1 1	868, 560		868, 560			201. 00
202.00	Total (see instructions)	26, 979, 439	0	26, 979, 439	0	0	202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/30/2017 11:41 am	
					Cost	
Cost Center Description	Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	4, 506, 422		4, 506, 422	)		30. 00
43. 00 04300 NURSERY	0		C	)		43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	448, 819	8, 615, 024	9, 063, 843		0.000000	
51. 00   05100   RECOVERY ROOM	0	0	(	0. 000000	0.000000	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0. 000000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	65, 468				0.000000	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	986, 780	24, 114, 963	25, 101, 743		0. 000000	
56. 00   05600   RADI OI SOTOPE	0	0			0.000000	1
60. 00   06000   LABORATORY	988, 564	9, 585, 397	10, 573, 961		0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TR	<b>1</b>	0		0. 000000	0.000000	
66. 00 06600 PHYSI CAL THERAPY	168, 303	3, 108, 542			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	77, 656				0.000000	
68. 00   06800   SPEECH PATHOLOGY	0	0		0.00000	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	930, 956				0.000000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA		1, 944, 242	2, 126, 997		0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			1, 119, 455	0. 314902	0.000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 761, 740	10, 901, 311	12, 663, 051	0. 347086	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	929, 130			0.000000	
90. 01   09001   SENI OR CARE	0	269, 764			0.000000	
91. 00   09100   EMERGENCY	347, 056				0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 0	705, 975	705, 975	1. 230299	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	869, 679	869, 679			101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	832, 669				116. 00
200.00 Subtotal (see instructions)	10, 469, 845	78, 293, 074	88, 762, 919			200. 00
201.00 Less Observation Beds						201. 00
202.00   Total (see instructions)	10, 469, 845	78, 293, 074	88, 762, 919	P[		202. 00

			10 12/31/2016	Date/lime Prep   5/30/2017 11:4	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00  03000 ADULTS & PEDIATRICS					30.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATI NG ROOM	0. 000000				50.00
51.00   05100   RECOVERY ROOM	0. 000000				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
56. 00   05600   RADI OI SOTOPE	0. 000000				56.00
60. 00   06000   LABORATORY	0. 000000				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00  09000  CLI NI C	0. 000000				90.00
90. 01   09001   SENI OR CARE	0. 000000				90. 01
91. 00   09100   EMERGENCY	0. 000000				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300   INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00   Total (see instructions)				l	202. 00

Hoal th	n Financial Systems P	ARKVIEW WABASH	UNC INTIDOOL		In Lio	u of Form CMS-2	2552 10
	TATION OF RATIO OF COSTS TO CHARGES	ARRVIEW WADASII	Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I	
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	3, 914, 241		3, 914, 24	1 0	3, 914, 241	30. 00
43. 00	04300 NURSERY	0			0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	2, 474, 099		2, 474, 09	0	2, 474, 099	50.00
51. 00	05100 RECOVERY ROOM	0			0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52. 00
53.00	05300 ANESTHESI OLOGY	16, 042		16, 04	2 0	16, 042	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 035, 912		3, 035, 91	2 0	3, 035, 912	54.00
56.00	05600 RADI OI SOTOPE	0			0 0	0	56. 00
60.00	06000 LABORATORY	1, 827, 986		1, 827, 98	86 0	1, 827, 986	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63. 00

1, 916, 929

1, 357, 954

4, 395, 172

151, 290

680, 558

352, 519

226, 571

459, 440

868, 560

691, 147

868, 560

27, 847, 999

26, 979, 439

4, 059, 420

1, 420, 159

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1, 916, 929

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1, 420, 159 101. 00

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868, 560 201. 00

27, 847, 999 200. 00

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691, 147

868, 560

27, 847, 999

26, 979, 439

0

4, 059, 420

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS

67. 00 06700 OCCUPATI ONAL THERAPY

09000 CLI NI C

09001 SENI OR CARE

101.00 10100 HOME HEALTH AGENCY

113. 00 11300 | I NTEREST | EXPENSE

116. 00 11600 HOSPI CE

09100 EMERGENCY

66.00

68.00

69 00

71.00

72.00

73.00

90.00

90. 01

91.00

92.00

200.00

201.00

202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	Provider CCN: 15-1310		Worksheet C Part I		
					To 12/31/2016	Date/Time Pre 5/30/2017 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 506, 422		4, 506, 42			30. 00
	04300 NURSERY	0			0		43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	448, 819	8, 615, 024	9, 063, 84		0. 000000	
	05100 RECOVERY ROOM	0	0		0. 000000	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
	05300 ANESTHESI OLOGY	65, 468	1, 205, 987			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	986, 780	24, 114, 963	25, 101, 74		0. 000000	
	05600 RADI OI SOTOPE	0	0		0. 000000	0. 000000	
	06000 LABORATORY	988, 564	9, 585, 397	10, 573, 96		0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	
	06600 PHYSI CAL THERAPY	168, 303	3, 108, 542			0. 000000	
	06700 OCCUPATI ONAL THERAPY	77, 656	156, 429			0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	930, 956	1, 827, 198			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	182, 755	1, 944, 242			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 326	1, 114, 129			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 761, 740	10, 901, 311	12, 663, 05	0. 347086	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	929, 130				
	09001 SENI OR CARE	0	269, 764				
	09100 EMERGENCY	347, 056	12, 112, 635			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	705, 975	705, 97	5 1. 230299	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS				_		
	10100 HOME HEALTH AGENCY	0	869, 679	869, 67	9		101. 00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	832, 669				116. 00
200.00	Subtotal (see instructions)	10, 469, 845	78, 293, 074	88, 762, 91	9		200. 00
201.00							201. 00
202.00	Total (see instructions)	10, 469, 845	78, 293, 074	88, 762, 91	9		202. 00

			10 12/31/2010	5/30/2017 11: 41 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATI NG ROOM	0. 272964			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 012617			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 120944			54.00
56. 00   05600   RADI 0I SOTOPE	0. 000000			56. 00
60. 00   06000   LABORATORY	0. 172876			60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
66. 00 06600 PHYSI CAL THERAPY	0. 584992			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 646304			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 492342			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 319962			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 314902			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 347086			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 243853			90. 00
90. 01   09001   SENI OR CARE	1. 703118			90. 01
91. 00   09100   EMERGENCY	0. 325804			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1. 230299			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

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

						5/30/2017 11:	41 am
			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	I Reduction	Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	2, 474, 099	339, 500	2, 134, 59	9 0	0	50. 00
51.00 0510	O RECOVERY ROOM	0	0	)	0 0	0	51.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0	0	)	0 0	0	52.00
53.00 0530	O ANESTHESI OLOGY	16, 042	7, 402	8, 64	0 0	0	53.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	3, 035, 912	311, 599	2, 724, 31	3 0	0	54. 00
56. 00 0560	O RADI OI SOTOPE	O	0		0	0	56. 00
60.00 0600	O LABORATORY	1, 827, 986	76, 750	1, 751, 23	6 0	0	60.00
63.00 0630	O BLOOD STORING, PROCESSING & TRANS.	0	O		0 0	0	63.00
66. 00 0660	O PHYSI CAL THERAPY	1, 916, 929	88, 574	1, 828, 35	5 0	0	66. 00
67. 00 0670	O OCCUPATIONAL THERAPY	151, 290	5, 389	145, 90	1 0	0	67. 00
	O SPEECH PATHOLOGY	O	. 0		0 0	0	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	1, 357, 954	80, 069	1, 277, 88	5 0	0	69. 00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	680, 558	29, 303			0	71. 00
72. 00 0720	O I MPL. DEV. CHARGED TO PATIENTS	352, 519	14, 903			0	72. 00
	O DRUGS CHARGED TO PATIENTS	4, 395, 172	182, 805			0	73. 00
	ATIENT SERVICE COST CENTERS				_		
90. 00 0900	O CLI NI C	226, 571	7, 740	218, 83	1 0	0	90.00
90. 01 0900	1 SENI OR CARE	459, 440	22, 170	437, 27	0 0	0	90. 01
91.00 0910	O EMERGENCY	4, 059, 420	176, 240	3, 883, 18	0 0	0	91. 00
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	868, 560	48, 393	820, 16	7 0	0	92.00
OTHE	R REIMBURSABLE COST CENTERS				<u> </u>	•	
	O HOME HEALTH AGENCY	1, 420, 159	58, 577	1, 361, 58	2 0	0	101. 00
SPEC	I AL PURPOSE COST CENTERS	<u> </u>	·		<u>'</u>		
113. 00 1130	O INTEREST EXPENSE						113. 00
116. 00 1160	O HOSPI CE	691, 147	24, 003	667, 14	4 0	0	116. 00
200.00	Subtotal (sum of lines 50 thru 199)	23, 933, 758	1, 473, 417	•			200.00
201.00	Less Observation Beds	868, 560	48, 393				201. 00
202.00	Total (line 200 minus line 201)	23, 065, 198	1, 425, 024	•			202.00
			•	•	•	•	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2016 | Part II | Date/Time Prepared: | 5/30/2017 | 11: 41 am REDUCTIONS FOR MEDICALD ONLY

					5/30/201/ 11: 4		
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charg	е		
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	2, 474, 099	9, 063, 843	0. 27296	4		50.00
	05100 RECOVERY ROOM	0	0	0.00000	0		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0		52.00
53.00	05300 ANESTHESI OLOGY	16, 042	1, 271, 455	0. 01261	7		53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 035, 912	25, 101, 743	0. 12094	4		54.00
56.00	05600 RADI OI SOTOPE	0	0	0.00000	0		56. 00
60.00	06000 LABORATORY	1, 827, 986	10, 573, 961	0. 17287	6		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0		63.00
66.00	06600 PHYSI CAL THERAPY	1, 916, 929	3, 276, 845	0. 58499	2		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	151, 290	234, 085	0. 64630	4		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0.00000	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 357, 954	2, 758, 154	0. 49234	2		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	680, 558	2, 126, 997	0. 31996	2		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	352, 519	1, 119, 455	0. 31490.	2		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 395, 172	12, 663, 051	0. 34708	6		73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	226, 571	929, 130	0. 24385	3		90. 00
90. 01	09001 SENI OR CARE	459, 440	269, 764	1. 70311	8		90. 01
91.00	09100 EMERGENCY	4, 059, 420	12, 459, 691	0. 32580	4		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	868, 560	705, 975	1. 23029	9		92.00
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		
101.00	10100 HOME HEALTH AGENCY	1, 420, 159	869, 679	1. 63296	9		101. 00
	SPECIAL PURPOSE COST CENTERS				<u>'</u>		
113.00	11300   NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	691, 147	832, 669	0. 83003	8		116. 00
200.00	Subtotal (sum of lines 50 thru 199)	23, 933, 758	84, 256, 497				200. 00
201.00		868, 560					201. 00
202.00	Total (line 200 minus line 201)	23, 065, 198	84, 256, 497				202. 00
	· · · · · · · · · · · · · · · · · · ·	•	•	•	*		•

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

Heal th	th Financial Systems PARKVIEW WABASH HOSPITAL, INC.					eu of Form CMS-2	2552-10
APPORTI	ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	Provi der CCN: 15-1310		Worksheet D Part II Date/Time Pre 5/30/2017 11:4	
			Title	· XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	339, 500	9, 063, 843			4, 514	
1	05100 RECOVERY ROOM	0	0	0.00000		0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52. 00
	05300 ANESTHESI OLOGY	7, 402					53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	311, 599	25, 101, 743			6, 492	
	05600 RADI OI SOTOPE	0	"	0.00000		0	56. 00
	06000 LABORATORY	76, 750	10, 573, 961			2, 786	1
1	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63. 00
1	06600 PHYSI CAL THERAPY	88, 574			· ·		66. 00
1	06700 OCCUPATI ONAL THERAPY	5, 389	234, 085		· ·	861	67. 00
	06800 SPEECH PATHOLOGY	0	0	0.00000		0	68. 00
	06900 ELECTROCARDI OLOGY	80, 069	,			8, 648	
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 303	2, 126, 997	0. 01377			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 903	1, 119, 455	0. 01331	3 1, 949	26	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	182, 805	12, 663, 051	0. 01443	6 734, 664	10, 606	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	7, 740	929, 130	0.00833	0	0	90. 00
	09001 SENI OR CARE	22, 170	269, 764	0. 08218		0	90. 01
1	09100 EMERGENCY	176, 240		l .		35	
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	48, 393	705, 975	0. 06854	.8	0	92. 00
200.00	Total (lines 50-199)	1, 390, 837	82, 554, 149	1	2, 249, 326	36, 834	200. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D
TUDOUGU COCTO			From 01/01/2016	Dart IV

From 01/01/2016 Part IV To 12/31/2016 Date/Time Prepared: 5/30/2017 11:41 am THROUGH COSTS Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost (sum of col 1 Anestheti st Medi cal  $through\ col.\\$ Cost Education Cost 1.00 2.00 4. 00 3.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 05600 RADI OI SOTOPE 56.00 56.00 0 0 60.00 06000 LABORATORY 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 01 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 0 0 0 0 0 0 0 90. 01 09001 SENI OR CARE 0 0 0 90.01 91. 00 09100 EMERGENCY 0 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 οl Total (lines 50-199) 200.00 0 200. 00

Health Financial Systems	PARKVI EW	u of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE O	Provider Co		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/30/2017 11:		
			Title	XVIII	Hospi tal	Cost	
Cost Center Description	To	otal T	otal Charges	Ratio of Cos	t Outpatient	I npati ent	

			'	0 12/31/2016	5/30/2017 11:	
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.	to Charges	Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0	9, 063, 843	1			
51. 00   05100   RECOVERY ROOM	0	0	0. 000000		0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0. 000000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	1, 271, 455	1		-	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	25, 101, 743	1		-	ł
56. 00   05600   RADI 0I SOTOPE	0	0	0. 000000			56. 00
60. 00   06000   LABORATORY	0	10, 573, 961	1			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63. 00
66. 00 06600 PHYSI CAL THERAPY	0	3, 276, 845	1		· ·	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	234, 085	1		· ·	1
68. 00   06800   SPEECH PATHOLOGY	0	0	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	2, 758, 154			· ·	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 126, 997	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 119, 455	1			
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	12, 663, 051	0.000000	0.000000	734, 664	73. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00  09000   CLI NI C	0	929, 130	0.000000	0.000000	0	90.00
90. 01   09001   SENI OR CARE	0	269, 764	0.000000	0.000000		90. 01
91. 00   09100   EMERGENCY	0	12, 459, 691	0.000000	0.000000	2, 490	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	705, 975	0.000000	0. 000000	0	92. 00
200.00   Total (lines 50-199)	0	82, 554, 149	1		2, 249, 326	200. 00

Health Financial Systems	PARKVIEW WABASH HOS	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 01/01/2016	Part IV

Inkough COSIS				To 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	9		
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCI LLARY SERVI CE COST CENTERS			T	1		
50. 00   05000   OPERATI NG ROOM	0	C	)	0		50. 00
51.00   05100   RECOVERY ROOM	0	C	)	0		51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	C	)	0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	C	)	0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	C	)	0		54. 00
56. 00   05600   RADI 0I SOTOPE	0	C	)	0		56. 00
60. 00   06000   LABORATORY	0	C	)	0		60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	)	0		63. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	)	0		67. 00
68.00 06800 SPEECH PATHOLOGY	0	C	)	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	)	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	)	0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	C	)	0		90. 00
90. 01   09001   SENI OR CARE	0	C		0		90. 01
91. 00   09100   EMERGENCY	0	C	)	0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	)	0		92. 00
200.00   Total (lines 50-199)	0	C	)	0		200. 00

Heal th	Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der Co		Period: From 01/01/2016 To 12/31/2016		pared: 41 am
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	1	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	0.0700/	1	1 0 00/ 5/			
50.00	05000 OPERATING ROOM	0. 272964		2, 006, 51	0	0	
51.00	05100 RECOVERY ROOM	0. 000000			0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
53. 00	05300 ANESTHESI OLOGY	0. 012617		288, 25		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 120944	1	7, 913, 95	0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000			0	0	56. 00
60.00	06000 LABORATORY	0. 172876		3, 606, 12	29 0	0	00.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0	0	63. 00
66. 00	06600 PHYSI CAL THERAPY	0. 584992		1, 007, 21		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 646304		53, 00	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 492342		342, 52		0	07.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 319962	1	257, 53		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 314902	1	176, 75		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 347086	0	5, 051, 80	00 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS			,			
90.00	09000 CLI NI C	0. 243853	1		0	0	
90. 01	09001 SENI OR CARE	1. 703118	1	208, 06		0	
91. 00	09100 EMERGENCY	0. 325804	1	3, 485, 91		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 230299	0	396, 31		0	
200.00			0	24, 793, 97	79 0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201. 00
202.00			0	24, 793, 97	79 0	0	202. 00

Provider CCN: 15-1310

				To 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	6. 00	7.00				
50. 00 05000 OPERATING ROOM	547, 706	0				50.00
51. 00   05100   RECOVERY   ROOM	347,700	0				51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   DEET VEKT   ROOM & EABOR ROOM   53. 00   05300   ANESTHESI OLOGY	3, 637	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	957, 145	0				54.00
56. 00   05600   RADI 0I SOTOPE	757, 145	0				56.00
60. 00   06000   LABORATORY	623, 413	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	023, 413	0				63. 00
66. 00   06600   PHYSI CAL THERAPY	589, 215	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 260	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	34, 200	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	168, 637	0				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	82, 400	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	55, 660	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 753, 409	0				73. 00
OUTPATIENT SERVICE COST CENTERS	1,700,107	<u> </u>				70.00
90. 00 09000 CLI NI C	0	0				90.00
90. 01   09001   SENI OR CARE	354, 351	0				90. 01
91. 00 09100 EMERGENCY	1, 135, 726	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	487, 582	0				92. 00
200.00 Subtotal (see instructions)	6, 793, 141	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	6, 793, 141	0				202. 00
	·					

Health Financial Systems	PARKVI EW WABASH HOS	SPITAL, INC.	In Lie	eu of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVICES AND MASSINE COST	D: -I CON 15 1010	D =! = -I	Wasaliaka A D

Period: From 01/01/2016 To 12/31/2016 Worksheet D Part V APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1310 Component CCN: 15-Z310 Date/Time Prepared: 5/30/2017 11:41 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. 272964 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.012617 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 120944 0 54.00 0 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 0 0 06000 LABORATORY 0 60.00 0. 172876 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 06600 PHYSI CAL THERAPY 0 66.00 0.584992 0 66.00 0 06700 OCCUPATIONAL THERAPY 67 00 67 00 0.646304 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 492342 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.319962 0 0 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0. 314902 Ω Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 347086 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 243853 0 0 0 90.00 00000 0 90.01 09001 SENI OR CARE 1.703118 90.01 0 0 0 91.00 09100 EMERGENCY 0. 325804 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 230299 0 92.00 92.00 0 Subtotal (see instructions) 0 200.00 0 0 200, 00 0 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 0 0 202.00

Health Financial Systems P	ARKVIEW WABAS	H HOS	PITAL, INC.			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND				CN: 15-1310 CCN: 15-Z310		01/01/2016 12/31/2016	Date/Time Pre	
			Title	XVIII	Swi ng	Beds - SNF	5/30/2017 11: Cost	41 аш
Cost Center Description	Cost	Costs	Cost					

		Component (	CCN: 15-Z310	То	12/31/2016	Date/Time Pro 5/30/2017 11	epared: : 41 am
		Title	XVIII	Swi ng	Beds - SNF		
	Co:	sts					
Cost Center Description	Cost	Cost					
	Rei mbursed	Rei mbursed					
	Servi ces	Servi ces Not					
	Subj ect To	Subject To					
	Ded. & Coi ns.	Ded. & Coins.					
	(see inst.)	(see inst.)	-				
ANOLLI ADV. CEDVI OF COCT. CENTEDO	6.00	7. 00					
ANCILLARY SERVICE COST CENTERS		1 0	I				
50. 00   05000   OPERATI NG   ROOM	0						50.00
51. 00   05100   RECOVERY ROOM							51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY							52. 00 53. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C							54.00
							•
56. 00   05600   RADI OI SOTOPE	0						56. 00 60. 00
60. 00   06000   LABORATORY 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.							63.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.							66.00
67. 00   06700   OCCUPATI ONAL THERAPY							67.00
68. 00   06800   SPEECH PATHOLOGY							68.00
69. 00   06900  ELECTROCARDI OLOGY							69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT							71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS							72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS							73. 00
OUTPATIENT SERVICE COST CENTERS		,	l				75.00
90. 00 09000 CLI NI C		0					90.00
90. 01   09001   SENI OR CARE							90. 01
91. 00 09100 EMERGENCY		0					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92. 00
200.00 Subtotal (see instructions)	0	0					200. 00
201.00 Less PBP Clinic Lab. Services-Progra	m O						201. 00
Only Charges							
202.00   Net Charges (line 200 +/- line 201)	0	0					202. 00

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				rom 01/01/2016		
			'	o 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Ti tI	e XIX	Hospi tal	PPS	11 4
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost	,		
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	218, 085	3, 687	214, 398	2, 268	94. 53	30. 00
43. 00 NURSERY	0			0	0.00	43.00
200.00 Total (lines 30-199)	218, 085		214, 398	2, 268		200. 00
Cost Center Description	I npati ent	Inpati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	28	2, 647				30. 00
43. 00 NURSERY	0	0	)			43.00
200.00 Total (lines 30-199)	28	2, 647				200. 00
,	•	•	•			•

Health Financial Systems	PARKVIEW WABASH HOSPI	I TAL,	I NC.	In Lie	u of Form CMS-2552-10

Health Financial Systems	PARKVIEW WABAS	H HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS	Provi der C	F	Period: From 01/01/2016	Worksheet D Part II	
			1	Го 12/31/2016	Date/Time Prep 5/30/2017 11:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. I		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col	. 8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	339, 50	9, 063, 843			97	50.00
51.00   05100   RECOVERY ROOM		0	0. 000000		0	51. 00
52. 00  05200   DELIVERY ROOM & LABOR RO		0 0	0. 000000		0	52. 00
53. 00   05300   ANESTHESI OLOGY	7, 40				0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	311, 5	99 25, 101, 743			509	54.00
56. 00   05600   RADI 0I SOTOPE		0 0	0. 000000		0	56. 00
60. 00  06000   LABORATORY	76, 7	10, 573, 961			173	
63.00 06300 BLOOD STORING, PROCESSIN	G & TRANS.	0 0	0.000000		0	63. 00
66. 00 06600 PHYSI CAL THERAPY	88, 5	3, 276, 845	0. 027030		10	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 38	39 234, 085	0. 023022	2 374	9	67. 00
68.00   06800   SPEECH PATHOLOGY		0 0	0.000000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	80, 0	59 2, 758, 15 <sup>4</sup>	0. 029030	9, 599	279	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT 29, 30	2, 126, 997	0. 013777	1, 735	24	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PA	TIENTS 14, 90	1, 119, 455	0. 013313	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENT	S 182, 80	12, 663, 051	0. 014436	48, 343	698	73. 00
OUTPATIENT SERVICE COST CENTER	RS .					
90. 00 09000 CLI NI C	7, 7	929, 130	0. 008330	0	0	90.00
90. 01   09001   SENI OR CARE	22, 1	70 269, 764	0. 082183	0	0	90. 01
91. 00 09100 EMERGENCY	176, 2	12, 459, 691	0. 014145	13, 831	196	91.00
92.00 09200 OBSERVATION BEDS (NON-DI	STINCT PART 48, 49	705, 975	0. 068692	0	0	92. 00
200.00 Total (lines 50-199)	1, 390, 9	82, 554, 149		141, 638	1, 995	200. 00
•	·			•	•	

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS	Provider Co		Period: From 01/01/2016	Worksheet D Part III		
				To 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 41 am	
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	Nursing School A	Allied Health	All Other	Swi ng-Bed	Total Costs		
		Cost	Medi cal	Adjustment	(sum of cols.		
			Education Cos	t Amount (see	1 through 3,		
				instructions)	minus col. 4)		
	1. 00	2.00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00	
43. 00   04300   NURSERY	o	0		o	0	43.00	
200.00 Total (lines 30-199)	o	0		o	0	200. 00	
Cost Center Description	Total Patient P	er Diem (col.	Inpati ent	I npati ent			
·	Days	5 ÷ col. 6)	Program Days	Program			
				Pass-Through			
				Cost (col. 7 x			
				col . 8)			
	6.00	7. 00	8. 00	9. 00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	2, 268	0.00	2	8 0		30.00	
43. 00   04300 NURSERY	o	0.00		ol o		43.00	
200.00 Total (lines 30-199)	2, 268		2	8 0		200. 00	
	, , , , ,		1	1	1		

Health Financial Systems	PARKVIEW WABASH HOS	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 01/01/2016	Part IV

THROUGH COSTS			Т	rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 41 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
	Anesthetist			Medical	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM		0	1	ا	0	50.00
51. 00   05100   RECOVERY ROOM		0			0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0		Ö	0	52.00
53. 00   05300   ANESTHESI OLOGY		0		Ö	0	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	o	0	d	o	0	54.00
56. 00   05600 RADI 0I SOTOPE	l ol	0	d	o	0	56. 00
60. 00   06000   LABORATORY	o	0		o	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0	ol c	o	0	63.00
66. 00 06600 PHYSI CAL THERAPY	o	0	ol c	o	0	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0	) c	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	) c	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	) c	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	) c	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000   CLI NI C	0	0	) C	0	0	90. 00
90. 01   09001   SENI OR CARE	0	0	) C	0	0	90. 01
91. 00   09100   EMERGENCY	0	0	C	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	0	0	92. 00
200.00   Total (lines 50-199)	0	0	() C	이	0	200. 00

Health Financial Systems	PARKVIEW WABASH HO	OSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SITHROUGH COSTS	ERVICE OTHER PASS	Provi der CC		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/30/2017 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		from Wkst. C,		Ratio of Cost	Inpatient Program Charges	

		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	1 8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00  05000 OPERATING ROOM		9, 063, 843	0.000000	0.000000	2, 601	50.00
51.00  05100 RECOVERY ROOM		0 0	0.000000	0.000000	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROO	M	0 0	0.000000	0.000000	0	52.00
53. 00   05300   ANESTHESI OLOGY		1, 271, 455	0.000000	0.000000	0	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C		25, 101, 743	0.000000	0.000000	41, 013	54.00
56. 00   05600 RADI 0I SOTOPE		0 0	0.000000	0.000000	0	56.00
60. 00   06000   LABORATORY		0 10, 573, 961	0.000000	0.000000	23, 790	60.00
63.00 06300 BLOOD STORING, PROCESSING	& TRANS.	0 0	0.000000	0.000000	0	63.00
66. 00 06600 PHYSI CAL THERAPY		3, 276, 845	0.000000	0.000000	352	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		234, 085	0.000000	0.000000	374	67.00
68.00 06800 SPEECH PATHOLOGY		0 0	0.000000	0.000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		2, 758, 154	0.000000	0.000000	9, 599	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT	2, 126, 997	0.000000	0.000000	1, 735	71.00
72.00 07200 I MPL. DEV. CHARGED TO PAT	TENTS	1, 119, 455	0. 000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	i	12, 663, 051	0. 000000	0.000000	48, 343	73.00
OUTPATIENT SERVICE COST CENTERS	5					
90. 00 09000 CLI NI C		929, 130	0.000000	0.000000	0	90.00
90. 01   09001   SENI OR CARE		269, 764	0. 000000	0.000000	0	90. 01
91. 00 09100 EMERGENCY		12, 459, 691	0. 000000	0.000000	13, 831	91.00
92. 00 09200 OBSERVATION BEDS (NON-DIS	TINCT PART	705, 975	0. 000000	0.000000	0	92.00
200.00 Total (lines 50-199)		82, 554, 149			141, 638	200. 00
	•	•	•		'	

Health Financial Systems	h Financial Systems PARKVIEW WABASH HOSPIT			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1310	Peri od:	Worksheet D		
THROUGH COSTS			From 01/01/2016	Part IV		

Title XIX				1	o 12/31/2016	Date/Time Pre 5/30/2017 11:	
Program Pass-Through Costs (col. 8 x col. 10)			Ti tl	e XIX	Hospi tal	PPS	
Pass-Through Costs (col . 8 x col . 10)   x col . 12)	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
ANCI LLARY SERVICE COST CENTERS   11.00   12.00   13.00							
ANCI LLARY SERVI CE COST CENTERS   11.00   12.00   13.00			Charges				
11.00   12.00   13.00							
ANCI LLARY SERVI CE COST CENTERS							
50.00   05000   0PERATI NG ROOM   0   0   0   0   0   0   0   0   0		11.00	12. 00	13. 00			
51.00		T					
52. 00       05200       DELI VERY ROOM & LABOR ROOM       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 STOPPE       0       0       0       0       56. 00         60. 00       06000       LABORATORY       0       0       0       0       60. 00         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       63. 00         64. 00       06600       PHYSI CAL THERAPY       0       0       0       63. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0       0       0       66. 00         68. 00       O6800       SPEECH PATHOLOGY       0       0       0       67. 00         68. 00       O6900       ELECTROCARDI OLOGY       0       0       0       69. 00         71. 00       O7100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       71. 00         73. 00       O7200       DRUGS C		0	C		)		
53. 00         05300         ANESTHESI OLOGY         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54. 00           56. 00         05600         RADI OLOGY-DI AGNOSTI C         0         0         0         55. 00           60. 00         05600         RADI OLOGY-DI AGNOSTI C         0         0         0         56. 00           60. 00         06000         LABORATORY         0         0         0         60. 00         60. 00           63. 00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0         0         0         63. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         63. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0         0         0         67. 00           68. 00         O6900         ELECTROCARDI OLOGY         0         0         0         68. 00           69. 00         O6900         ELECTROCARDI OLOGY         0         0         0         77. 00		0	C		)		
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       54. 00         56. 00       05600       RADI OLOGY-DI AGNOSTI C       0       0       0       0       56. 00         60. 00       06000       LABORATORY       0       0       0       0       60. 00         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       63. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       0       63. 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       68. 00         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73. 00		0	C		)		
56. 00       05600 RADI OI SOTOPE       0       0       0       56. 00         60. 00       06000 LABORATORY       0       0       0       0       60. 00         63. 00       06300 BLOOD STORI NG, PROCESSI NG & 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       66. 00         68. 00       06800 SPEECH PATHOLOGY       0       0       0       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0       0       0       69. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       71. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0       0       0       73. 00         00 O9000 CLI NI C       0       0       0       90. 01         90. 01       09001 SENI OR CARE       0       0       0       90. 01         91. 00       09200 OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0		0	C		)		
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0		0	C		)		
63. 00		0	C		)		
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   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   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73. 00   09000   CLI NI C   0   0   0   90. 01   09000   SENI OR CARE   0   0   0   91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   95. 00   00   00   0   96. 00   00   00   0   97. 00   09200   00   00   00   98. 00   00   00   00   99. 01   09200   00   00   99. 01   09200   00   00   00   99. 01   09200   00   00   99. 01   09200   00   00   99. 01   00   00   00   99. 01   00   00		0	C	) (	)		
67. 00		0	C	) (	)		
68. 00		0	C	) (	)		
69. 00   06900   ELECTROCARDI OLOGY   0 0 0 0 0   69. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0   73. 00   07300		0	C	) (	)		
71. 00		0	C	) (	)		
72. 00   07200   1MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		0	C	) (	)		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		0	C	) (	)		
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         0         0         90. 00           90. 01         09001 SENI OR CARE         0         0         0         90. 01           91. 00         09100 EMERGENCY         0         0         0         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         92. 00		0	C	) (	)		
90. 00   9000   CLI NI C   0   0   0   90. 00   90. 01		0	C	) (	)		73. 00
90. 01   09001   SENI OR CARE							_
91. 00   09100   EMERGENCY   0   0   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   92. 00		0	C	) (	)		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00		0	C	) (	)		1
		0	C	) (	)		
200.00   Total (lines 50-199)   0  0  0   200.00		0	C	) (	)		
	200.00   Total (lines 50-199)	0	C	)  (	)		200. 00

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 11:	epared: 41 am
		Ti tl	e XIX	Hospi tal	PPS	
			Charges	_	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
	1.00		(see inst.)	(see inst.)		
ANOTHER DESIGNATION OF THE POST OF THE POS	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	0.0700//		T			
50. 00   05000   OPERATING ROOM	0. 272964			0 61, 072	0	
51. 00 05100 RECOVERY ROOM	0. 000000			0	0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0	0	
53. 00   05300   ANESTHESI OLOGY	0. 012617	l .		0 5, 845	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 120944	l .		0 265, 587	0	
56. 00   05600   RADI 0I SOTOPE	0. 000000			0	0	
60. 00   06000   LABORATORY	0. 172876	l .		0 202, 734	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 584992			0 20, 525	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 646304	l e		0 6, 763	0	
68.00 06800 SPEECH PATHOLOGY	0. 000000	l e		0	0	
69. 00  06900   ELECTROCARDI OLOGY	0. 492342	0		0 3, 215	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 319962	0		0 36, 569	0	1 / 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 314902			0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 347086	0		0 137, 076	0	73. 00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00  09000  CLI NI C	0. 243853	l e		0	0	
90. 01  09001   SENI OR CARE	1. 703118	l e		0	0	
91. 00  09100   EMERGENCY	0. 325804	l e		0 318, 328	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 230299	0		0 8, 083	0	
200.00 Subtotal (see instructions)		0		0 1, 065, 797	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 1, 065, 797	0	202. 00

				To 12/31/2016		
		Ti tl	e XIX	Hospi tal	PPS	41 аш
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOTHER OF THE CONTROL OF THE CONTRO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	1	4, ,70	I			
50. 00   05000   OPERATING ROOM	0	16, 670				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY		74				52. 00 53. 00
		1				54.00
		32, 121				
56. 00   05600   RADI 0I SOTOPE 60. 00   06000   LABORATORY		0	1			56. 00 60. 00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		35, 048 0	1			63. 00
66. 00 06600 PHYSI CAL THERAPY		12, 007				66.00
67. 00 06700 OCCUPATIONAL THERAPY		4, 371				67. 00
68. 00   06800   SPEECH PATHOLOGY		4, 3/1				68. 00
69. 00   06900   ELECTROCARDI OLOGY		1, 583				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		11, 701				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		11,701	1			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			1			73. 00
OUTPATIENT SERVICE COST CENTERS		17,077				70.00
90. 00 09000 CLI NI C	0	0				90.00
90. 01   09001   SENI OR CARE	0	Ö				90. 01
91. 00 09100 EMERGENCY	0	103, 713				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9, 945	1			92.00
200.00 Subtotal (see instructions)	0	274, 810				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	0	274, 810				202. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 5/30/2017 11:41 am	
	Title XVIII	Hospi tal	Cost	

Cost Center Description  PART 1 - ALL PROVIDES COMPONENTS    PART 1 - ALL PROVIDES COMPONENTS				12, 01, 2010	5/30/2017 11:	41 am
PART   All PROVIDER COMPONENTS			Title XVIII	Hospi tal	Cost	
Inpatt in the days (including private room days and saing-bed days, excluding newborn)   2,374   1,00   1		Cost Center Description			4 00	
NAME		DADT I ALL DROWLDED COMPONENTS			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days), excluding swing-bed and newborn days)   2,268   2,00   3,00   Private room days (secluding swing-bed and observation bed days). It you have only private room days.   3,00	1 00		excluding newhorn)		2 374	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SWF type inpatient days (including private room days) through Docember 31 of the cost reporting period (if call earlier year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if call earlier year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if call earlier year, enter 0 on this line).  8.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if patient) days including private room days) after December 31 of the cost reporting period (if patient) days including private room days applicable to the Program (excluding swing-bed and nexborn days).  9.00 Swing-bed SWF type inpatient days applicable to the Itia XVIII only (including private room days) after December 31 of the cost reporting period (it its XVIII only (including private room days) after December 31 of the cost reporting period (it its XVIII only (including private room days) after December 31 of the cost reporting period (it is XVIII only (including private room days) after December 31 of the cost reporting period (it is XVIII only (including private room days) after December 31 of the cost reporting period (it called the XVIII only (including private room days) after December 31 of the cost reporting period (it is XVIII only (including private room days) after December 31 of the cost reporting period (it is XVIII only (including private room days) after December 31 of the cost reporting period (it is XVIII only (it called a room including private room days) after December 31 of the cost reporting period (it is XVIII only (it called a room including private room days)						
do not complete this line.  4. 05 Semi-private room days (sectualing swing-bed and observation bed days)  7. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7. Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7. Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  8. Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  9. Total lingstient days including private room days after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10. Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  10. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after SNF type inpatient days applicable to the Program (excluding private room days)  11. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  12. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  13. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  14. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  15. Swing-bed SNF type inpatient days applicable to the Program (excluding private room days)  16. Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed applicable to Program (excluding swing-bed applicable to Program (excluding swing-bed days)  17. Swing-bed SNF type inpatient days applicable to Program (excluding swing-bed days)  18. Swing-bed SNF type inpatient private room days)  18. Swing-bed SNF type inpatient private room days applicable to Pro				ivate room days		
5.00   Semi-private room days (excluding swing-bed and observation bed days)   1.755   4.00	0.00		ys). It you have omly pr	rvate room days,	Ŭ	0.00
reporting period (if calendar year, enter 0 on this line) 7.00 7.01 7.00 7.01 7.00 7.00 7.00 7.00	4.00	· ·	ed days)		1, 755	4. 00
1   10   10   10   10   10   10   10	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	39	5.00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total sing-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) 9. 00 Total inpatient days including private room days after December 31 of the cost 0 8 8 00 revotor days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after 0 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 12. 00 Swing-bed Cost applicable Swing-bed Swing-bed Swing-bed Swi						
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)   Cost   Co	6.00		om days) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed Simber 31 of the cost reporting period (see instructions)  11. 00 Swing-bed Simber 31 of the cost reporting period (see instructions)  12. 00 Swing-bed Simber 31 of the cost reporting period (see instructions)  13. 00 Swing-bed Simber 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Swing-bed NF type inpatient days applicable to 11 its XVIII only (including private room days) after become 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed NF type inpatient days applicable to 11 its XVIII only (including private room days) 0 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  16. 00 Iburser Box Allies or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 10 murser days (if it is V or XIX only) 0 15. 00 10 10 10 10 10 10 10 10 10 10 10 10					,_	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (ir Catendary syear, enter 0 on this line)   Solid newborn days)   Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)   39   10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   39   10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after   12.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   12.00   Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)   14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   14.00   Medical private room days applicable to the Program (excluding swing-bed days)   15.00   1	7.00		n days) through December	31 of the cost	67	7.00
reporting period (If Callendar 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 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through 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 on through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) on through December 31 of the cost reporting period (including private room days) after control of the system of the cost reporting period (including private room days) on the cost rep	8 00		days) after December 3	1 of the cost	Ō	8 00
10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   39   10.00	0.00		days) arter becomber 5	1 of the cost	O	0.00
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 becember 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 becember 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 only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (Title V or XIX only)  16.00 Nursery days (Title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x including service)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x including service)  19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x including service)  29.00 Swin	9.00		the Program (excluding	swing-bed and	863	9. 00
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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 General inpatient routine service charges (excluding swing-bed and observation bed charges)  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 29 ÷ line 3)  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 3, 839, 961)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		x line 18)	•			
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) 74, 280 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8.00 PRIVATE 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) 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 3, 839, 961) 37.00 Private room cost differential adjustment (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24. 00		31 of the cost reporti	ng period (line	8, 249	24. 00
x line 20) Total swing-bed cost (see instructions) 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) 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 3, 839, 961) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average per diem private room cost differential (line 3, 839, 961) Average pe	25 00	,	04 -£ +b+		0	25 00
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)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Ajusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25.00		si of the cost reporting	period (line 8	0	25.00
27. 00   Conceral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,839,961   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00     General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Pri vate room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-private room charges (excluding swing-bed charges)   0   30. 00     General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0. 0000000     31. 00   32. 00   Average pri vate room per diem charge (line 29 ÷ line 3)   0. 00   32. 00     33. 00   Average semi-private room per diem charge (line 30 ÷ line 4)   0. 00   32. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 00     36. 00   Private room cost differential adjustment (line 3 x line 35)   0   36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)   0. 00     PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,693. 10   38. 00     39. 00   Program general inpatient routine service cost per diem (see instructions)   1,693. 10   38. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00	26 00				74 280	26 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  10 29. 00  10 29. 00  11 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  12 00 Average private room per diem charge (line 29 ÷ line 3)  13 00 Average semi-private room per diem charge (line 30 ÷ line 4)  14 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  15 00 Average per diem private room cost differential (line 34 x line 31)  16 00 Average per diem private room cost differential (line 34 x line 31)  17 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  17 00 Adjusted general inpatient routine service cost per diem (see instructions)  18 00 Adjusted general inpatient routine service cost (line 9 x line 38)  19 00 Program general inpatient routine service cost (line 9 x line 38)  10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			(line 21 minus line 26)		-	
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 29 ÷ line 3)  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 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00  29.00  30.00  30.00  30.00  30.00  31.00  30.00  32.00  32.00  34.00  35.00  36.00  37.00  36.00  37.00  38.00  37.00				<u>'</u>		
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) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 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 3, 839, 961) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 0.00 0.00 0.00 0.00 0.00 0.00	28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
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)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  31.00  0.00 32.00  32.00  32.00  32.00  33.00  34.00  35.00  36.00  36.00 Private room cost differential (line 3 x line 35)  0.00 35.00  36.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 839, 961)  37.00 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 (line 9 x line 38)  1,693.10  1,461,145  39.00	29. 00	Private room charges (excluding swing-bed charges)				29. 00
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 3, 839, 961) 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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00	30.00					
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 3, 839, 961)  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 (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 33.00  37.00 36.00  37.00 37.00  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 693.10 38.00  1, 461, 145 39.00		,	: line 28)			
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 3, 839, 961)  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 (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 34.00  36.00 37.00  37.00 27 minus line 36)  17.693.10 38.00  18.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  19.00 40.00						
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 3, 839, 961)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			11 00) (			
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 3, 839, 961 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, 693.10 1, 461, 145 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , ,		tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 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)  97.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 And the program (line 14 x line 35)  37.00 And the program (line 14 x line 35)		· · · · · · · · · · · · · · · · · · ·				
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)  1,693.10 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,461,145 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			and private room cost di	fferential (line		
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)  1,693.10 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,461,145 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00	,	and private room cost ur	c. c c c c c c c	3, 037, 701	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,693.10 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,461,145 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,461,145 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 693. 10	38. 00
		, , ,	•			
41.00   Iotal Program general inpatient routine service cost (line 39 + line 40)   1,461,145   41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)		1, 461, 145	41.00

Heal th	Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1310 Period: From 01/01/2016	Worksheet D-1	
	To 12/31/2016	Date/Time Pre 5/30/2017 11:	
	Title XVIII Hospital  Cost Center Description Total Total Average Per Program Days	Cost Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 0 0.00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description		47. 00
	·	1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	651, 807 2, 112, 952	48. 00 49. 00
	PASS THROUGH COST ADJUSTMENTS		
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program discharges Target amount per discharge	0 0. 00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60. 00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61. 00
(0.00	amount (line 56), otherwise enter zero (see instructions)		,,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)	0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	66, 031	64. 00
	instructions)(title XVIII only)		
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	66, 031	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
	(line 13 x line 20)		
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72. 00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line 76)		77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)		83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	513 1, 693. 10	•
	Observation bed cost (line 87 x line 88) (see instructions)	868, 560	

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC.				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
					5/30/2017 11:	41 am_
		Title	XVIII	Hospi tal	Cost	
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 (	COST					
90.00 Capital -related cost	218, 085	3, 914, 241	0. 05571	6 868, 560	48, 393	90. 00
91.00 Nursing School cost	0	3, 914, 241	0.00000	0 868, 560	0	91. 00
92.00 Allied health cost	0	3, 914, 241	0.00000	0 868, 560	0	92. 00
93.00 All other Medical Education	0	3, 914, 241	0. 00000	0 868, 560	0	93. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1310	Peri od: From 01/01/2016	Worksheet D-1	
			Date/Time Pre 5/30/2017 11:	
	Title XIX	Hospi tal	PPS	
Cost Contor Doscription			•	

		Title XIX	Hospi tal	5/30/2017 11: PPS	41 am_
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			2, 374 2, 268	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 755	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	39	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	67	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	28	9. 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)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost		17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period				18. 00
19. 00	Medical drate for swing-bed NF services applicable to services reporting period	9			19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	3, 914, 241 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	·		0	23. 00
	x line 18)	•		-	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	·		0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December $3 \times 1$ ine 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	Tine 21 minus line 26)		66, 171 3, 848, 070	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30. 00				0	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	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lir		<i>'</i>	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 848, 070	
	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, 696. 68	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			47, 507	39. 00
40.00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		47, 507	41. 00

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, IN	C.	In Li€	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1310	Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		
				tle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Da	Average Per ys Diem (col. 1		Program Cost	
				col. 2)		4)	
42.00	NUDCEDY (+i+lo V 0 VIV only)	1.00	2. 00	3.00	4.00	5. 00	42. 00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.0	0		42.00
43. 00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			36, 797	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	see instruct	i ons)		84, 304	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine	services (fr	om Wkst. D, sun	n of Parts I and	2, 647	50. 00
51. 00	<pre> III)  Pass through costs applicable to Program inp.</pre>	atient ancillar	y services (	from Wkst. D, s	sum of Parts II	1, 995	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				4, 642	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-p	hysician anesth	etist, and	79, 662	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	•
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount	(line 56 minus	line 53)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and te	irget amount	(TTTIC 30 IIITTIGS	11110 33)	o o	•
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. up	dated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the le	esser of 50% of	-	0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54	x 60), or 1% of	the target		
62. 00	Relief payment (see instructions)	ŕ				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	he cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	e 65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions)					0	67. 00
	(line 12 x line 19)	Ü					
	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ lin	ne 2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x	line 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 7	(3)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	n Worksheet B, F	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der reco	ords)			79. 00
80.00	Total Program routine service costs for comp	arison to the o			nus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (		* .				83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 66	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	Jug.1 00)				33.30
87. 00	Total observation bed days (see instructions		Line 2)			513	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		TITIE 2)			1, 696. 68 870, 397	
		,				,	

Health Financial Systems Pa	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared: 41 am
		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 (	COST					
90.00 Capital -related cost	218, 085	3, 914, 241	0. 05571	6 870, 397	48, 495	90.00
91.00 Nursing School cost	0	3, 914, 241	0.00000	0 870, 397	0	91.00
92.00 Allied health cost	0	3, 914, 241	0.00000	0 870, 397	0	92.00
93.00 All other Medical Education	0	3, 914, 241	0. 00000	0 870, 397	0	93. 00

	WABASH HOSPITAL, INC.			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co		Peri od: From 01/01/2016	Worksheet D-3	
			To 12/31/2016		
-	Title	: XVIII	Hospi tal	Cost	41 411
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			1, 500, 238		30. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 27296		32, 893	
51.00   05100   RECOVERY ROOM		0.00000		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
53. 00   05300   ANESTHESI OLOGY		0. 01261			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 12094			
56. 00   05600   RADI 0I SOTOPE		0.00000		0	56. 00
60. 00   06000   LABORATORY		0. 17287		1	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
66. 00 06600 PHYSI CAL THERAPY		0. 58499		41, 104	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 64630		1	
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 49234	· ·		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31996	· ·	20, 787	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31490			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 34708	734, 664	254, 992	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 24385		0	90. 00
90. 01   09001   SENI OR CARE		1. 70311		0	90. 01
91. 00   09100   EMERGENCY		0. 32580		811	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 23029		0	
200 00   Total (sum of lines 50 04 and 06 09)		I .	2 2/0 226	451 007	

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

Net Charges (line 200 minus line 201)

811 91.00 0 92.00 651,807 200.00

201. 00 202. 00

202.00

	PARKVIEW WABASH HOSPITAL, INC.		In Lieu of Form CMS-2552-10		
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co		Period: From 01/01/2016	Worksheet D-3	
	Component		To 12/31/2016	Date/Time Pre	
	·			5/30/2017 11:	41 am
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
43. 00   04300   NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50, 00 O5000 OPERATING ROOM		0, 27296	4 0	0	50.00
51. 00   05100   RECOVERY ROOM		0. 00000		0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0.00000		ő	
53. 00   05300   ANESTHESI OLOGY		0. 01261		o o	
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 12094			
56. 00   05600 RADI 0I SOTOPE		0.00000	· ·	0	1
60. 00   06000   LABORATORY		0. 17287			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	· ·	0	1
66. 00   06600   PHYSI CAL THERAPY		0. 58499			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 64630	· ·		
68. 00 06800 SPEECH PATHOLOGY		0.00000	· ·	0	1
69. 00   06900   ELECTROCARDI OLOGY		0. 49234	2, 644	1, 302	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31996	2 1, 056	338	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31490		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 34708	6 11, 423	3, 965	73.00
OUTPATIENT SERVICE COST CENTERS		•			1
90. 00 09000 CLI NI C		0. 24385	3 0	0	90. 00
90. 01   09001   SENI OR CARE		1. 70311	8 0	0	90. 01
91. 00 09100 EMERGENCY		0. 32580	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 23029	9 0	0	92.00
200 00 Total (sum of lines 50-94 and 96-98)		[	/1 001	17 722	200 00

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

Net Charges (line 200 minus line 201)

202. 00

0 92.00 17,723 200.00 201. 00

202.00

Health Financial Systems PARKVIEW WABAS	H HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016		
	Ti tl	e XIX	Hospi tal	PPS	
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			51, 714		30. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS		,	_		
50. 00   05000   OPERATING ROOM		0. 27296		1	
51. 00   05100   RECOVERY ROOM		0.00000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
53. 00   05300   ANESTHESI OLOGY		0. 01261		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 12094		4, 960	
56. 00   05600   RADI 0I SOTOPE		0.00000		0	56. 00
60. 00   06000   LABORATORY		0. 17287		4, 113	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63. 00
66. 00   06600 PHYSI CAL THERAPY		0. 58499			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY		0. 64630		242	67. 00
68. 00   06800   SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 49234			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31996	2 1, 735	555	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31490	2 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 34708	6 48, 343	16, 779	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 24385	3 0	0	90. 00
90. 01   09001   SENI OR CARE		1. 70311	8 0	0	90. 01
04 00 00400 EMEDOENOV		0 00500	40.004	4 50/	04 00

1. 703118 0. 325804 1. 230299

91.00

92.00 0 36, 797 200. 00 201. 00

202. 00

4, 506

91. 00 09100 EMERGENCY

202.00

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50-94 and 96-98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net Charges (line 200 minus line 201)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	From 01/01/2016	Worksheet E Part B Date/Time Prepared: 5/30/2017 11:41 am

			To 12/31/2016	Date/Time Pre 5/30/2017 11:	
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			6, 793, 141	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		0	2. 00
3.00	PPS payments			0	3. 00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	4. 00 5. 00
6. 00	Line 2 times line 5	2013)		0.000	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	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 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 793, 141	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 793, 141	11.00
	Reasonabl e charges				
12.00	Ancillary service charges	(0)		0	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00 14. 00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	1 3	n a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.00000	47.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds li	ne 11) (see	0	19. 00
	instructions)	,	, (===		
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		6, 861, 072	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	24. 00	
25. 00	Deductibles and coinsurance (for CAH, see instructions)			46, 512	25. 00
26.00					26. 00
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, 511, 586	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	116 30)		Ö	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 511, 586	30. 00
31. 00	Primary payer payments			1, 986	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	YEC)		2, 509, 600	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,E3)		0	33. 00
34. 00	Allowable bad debts (see instructions)			324, 404	
35. 00	Adjusted reimbursable bad debts (see instructions)			210, 863	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		324, 404	
37. 00	Subtotal (see instructions)   MSP-LCC reconciliation amount from PS&R			2, 720, 463	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions)   Sequestration adjustment (see instructions)			2, 720, 463 54, 409	1
41. 00	Interim payments			3, 566, 661	1
42. 00					42. 00
43.00				-900, 607	•
44. 00	Protested amounts (nonallowable cost report items) in accordance in acco	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	
94. UU	Total (sum of lines 91 and 93)		ı	0	94. 00

Health Financial Systems

PARKVIEW WABASH HOSPITAL, INC.

In Lieu of Form CMS-2552-10

Provider CCN: 15-1310

Period:
From 01/01/2016
To 12/31/2016

Part I
Date/Time Prepared:
5/30/2017 11: 41 am

Inpatient Part A

Part B

mm/dd/yyyy Amount mm/dd/yyyy Amount
1.00 2.00 3.00 4.00

1.00 Tatal interim payments paid to provider

	Title	XVIII	Hospi tal	Cost	
	Inpatien	it 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, 028, 579		3, 518, 861	1. 00
2.00 Interim payments payable on individual bills, either		0			2.00
submitted or to be submitted to the contractor for					
services rendered in the cost reporting period. If no	ne.				
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	e l				
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1)					
Program to Provider	•				
3. 01 ADJUSTMENTS TO PROVIDER		0	09/01/2016	47, 800	3. 01
3. 02		l o	077 017 2010	0	3. 02
3. 03		0			3. 03
3.04		0			3. 04
		0			
3. 05		0			3. 05
Provi der to Program					0 50
3. 50 ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51		0		0	3. 51
3. 52		0		0	3. 52
3. 53		0		0	3. 53
3. 54		0		0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		47, 800	3. 99
3. 50-3. 98)					
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		2, 028, 579		3, 566, 661	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	r				5.00
desk review. Also show date of each payment. If none,					
write "NONE" or enter a zero. (1)					
Program to Provider					
5. 01 TENTATI VE TO PROVI DER		0		0	5. 01
5. 02		0		0	5. 02
5. 03		0		0	5. 03
Provider to Program	·				
5. 50 TENTATI VE TO PROGRAM		0		0	5. 50
5. 51		0		0	5. 51
5. 52		0		0	5. 52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 99
5. 50-5. 98)					5. 77
6.00 Determined net settlement amount (balance due) based or	3				6. 00
the cost report. (1)	1				0.00
6. 01 SETTLEMENT TO PROVIDER		0		o	6. 01
				1 01	
6.02   SETTLEMENT TO PROGRAM		-		000 (07)	
7 00 T-+-1 M-di		153, 714		900, 607	6. 02
7.00 Total Medicare program liability (see instructions)		-		2, 666, 054	7. 00
7.00 Total Medicare program liability (see instructions)		153, 714	Contractor	2,666,054 NPR Date	
7.00 Total Medicare program liability (see instructions)		153, 714 1, 874, 865	Number	2,666,054 NPR Date (Mo/Day/Yr)	
7.00 Total Medicare program liability (see instructions)  8.00 Name of Contractor		153, 714		2,666,054 NPR Date	

 Heal th
 Financial
 Systems
 PARKVI

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED

		· ·			5/30/2017 11:	41 am
				ving Beds - SNF		
		Inpatien	it 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		75, 811		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		75, 811		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
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	T	1 -		1	
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03			0		0	5. 03
F F0	Provi der to Program				1 0	
5. 50	TENTATI VE TO PROGRAM		0		0	1
5. 51			0		0	
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		7, 088		0	6. 01
	SETTLEMENT TO PROVIDER		7,088			1
6. 02			02 222		0	
7. 00	Total Medicare program liability (see instructions)		82, 899		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
			 )	1. 00	2. 00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
3.00	Induite of contractor	I		l	I	1 0.00

Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu o					2552-10
CALCUL	From 01/01/2016 F To 12/31/2016 D				
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		14	645 863	1. 00 2. 00
2.00	2.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		1, 755	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			88, 762, 919	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			1, 201, 001	6. 00
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			21, 329	8. 00
9.00	Sequestration adjustment amount (see instructions)			427	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		20, 902	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32 00	Ralance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ne)	20 902	32 00

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

20, 902 32. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 15-1310	Peri od: From 01/01/2016	Worksheet E-2
		Component CCN: 15-Z310	To 12/31/2016	Date/Time Prepared: 5/30/2017 11:41 am

	Component Con. 13-2310	10 12/31/2010	5/30/2017 11:	
	Title XVIII	Swing Beds - SNF	Cost	
		Part A	Part B	
		1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	66, 691	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D,	17, 900	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			
4.00	Per diem cost for interns and residents not in approved teaching program (see		0. 00	4. 00
	instructions)		_	
5.00	Program days	39	0	
6.00	Interns and residents not in approved teaching program (see instructions)		0	1 0.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	84, 591	0	
9.00	Primary payer payments (see instructions)	0	0	
10.00	Subtotal (line 8 minus line 9)	84, 591	0	1
11. 00	Deductibles billed to program patients (exclude amounts applicable to physician	0	0	11. 00
12.00	professional services)	04 501	0	12.00
	Subtotal (line 10 minus line 11)	84, 591	0	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	U	0	13.00
14. 00	80% of Part B costs (line 12 x 80%)		0	14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	84, 591	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	04, 571	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		0	
	410A RURAL DEMONSTRATION PROJECT		O	16. 55
	Allowable bad debts (see instructions)		0	•
	Adjusted reimbursable bad debts (see instructions)		0	
	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	
	Total (see instructions)	84, 591	0	
	Sequestration adjustment (see instructions)	1, 692	0	1
	Interim payments	75, 811	0	20.00
	Tentative settlement (for contractor use only)	0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	7, 088	0	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	0	0	1
20.00	chapter 1, §115. 2		ŭ	=0.00

Health Financial Systems	PARKVIEW WABASH HOSPITA	In Lieu of Form CMS-255			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro		From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Prepared: 5/30/2017 11:41 am	
		Title XVIII	Hosni tal	Cost	

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT   1.00				10 12,01,2010	5/30/2017 11:	41 am
PART V - CALCILATION OF RELIMBUSSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIMBUSSEMENT			Title XVIII	Hospi tal		
PART V - CALCILATION OF RELIBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIBURSEMENT						
Inpatient services   2, 112, 952   1.00					1. 00	
Inpatient services   2,112,952   1.00   1.		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
2.00   Nursing and Allied Heal th Managed Care payment (see instructions)	1.00				2, 112, 952	1.00
Organ acquisition   0   3.00		'	ons)			1
Subtotal   Sum of lines 1 through 3   2,112,952   4,00   0,00						
Primary payer payments						ł
Consideration of testing   Consideration   C		,				1
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   Routine service charges   0 8.00		1 3 . 3 . 3			ı	
Reasonable charges	0.00				2, 134, 002	0.00
Routine service charges						1
Accillary service charges   0   8. 00   9. 00   0. 0	7 00				0	7 00
0   0.00   0rgan acquisition charges, net of revenue   0   9.00   0.00		1			-	
10. 00   Total reasonable charges   0   10. 00   Customary charges   0   10. 00   Customary charges   11. 00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   12. 00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12. 00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12. 00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12. 00   12. 00   13. 00   14. 00   15. 00		, ,				
Customary charges		] 3 '			-	
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis 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 1.00000)  13.00 Total customary charges (see instructions)  15.00 Excess of customary charges (see instructions)  16.00 Excess of reasonable cost over customary charges (complete only if line 14 exceeds line 6) (see instructions)  17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)  17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)  18.00 Direct graduate medical education payments (from Worksheet E-4, line 49)  19.00 Cost of physicians' services (sum of lines 6, 17 and 18)  19.00 Excess reasonable cost (from line 16)  20.10 Excess reasonable cost (from line 16)  21.00 Excess reasonable cost (from line 16)  22.10 Excess reasonable cost (from line 20 and 21)  23.00 Coinsurance  24.00 Subtotal (line 22 minus line 23)  25.00 Aljusted reimbursable bad debts (exclude bad debts for professional services) (see instructions)  26.00 Ajusted reimbursable bad debts (see instructions)  27.10 Allowable bad debts (exclude bad debts (see instructions)  28.00 Subtotal (sum of lines 24 and 25. or line 26)  29.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)  10.00 Excess reasonable cost (rearted Depreciation and justment (see instructions)  20.00 Excess reasonable cost (sum of lines 30 minus lines 30.01, 31, and 32)  20.01 Contact of the service of the contractor use only)  20.02 Contract of the service of the contractor use only)  20.03 Subtotal (sum of lines 24 and 25. or line 26)  20.04 Excess reasonable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	10.00	· · · · · · · · · · · · · · · · · · ·			U	10.00
12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)   0.000000   13.00   14.00   14.00   14.00   15.00   14.00   14.00   14.00   15.00   14	11 00				0	11 00
Nad Such payment been made in accordance with 42 CFR 413.13(e)   Ratio of line 11 to line 12 (not to exceed 1.000000)   0.000000   13.00   14.00   15.00   Excess of customary charges (see instructions)   0.14.00   15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   15.00						1
13.00	12.00	· ·	1 3	n a charge basis	U	12.00
14. 00 Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 Cost of physicians' services in a teaching hospital (see instructions) 18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19. 00 Cost of covered services (sum of lines 6, 17 and 18) 19. 00 Deductibles (exclude professional component) 20. 00 Deductibles (exclude professional component) 21. 00 Excess reasonable cost (from line 16) 22. 00 Subtotal (line 19 minus line 20 and 21) 23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27. 01 Allowable bad debts (exclude bad debts (see instructions) 28. 02 Allowable bad debts for dual eligible beneficiaries (see instructions) 29. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 01 Subtotal (see instructions) 30. 02 Subtotal (see instructions) 30. 03 Subtotal (see instructions) 30. 04 Subtotal (see instructions) 30. 05 Subtotal (see instructions) 30. 07 Subtotal (see instructions) 30. 08 Subtotal (see instructions) 30. 09 Subtotal (see instructions) 30. 00 Subtotal (see instructions) 30. 01 Iner im payments 30. 02 Subtotal (see instructions) 30. 03 Sequestration adjustment (see instructions) 30. 01 Iner im payments 30. 02 Subtotal (see instructions) 31. 00 Inter mayments 32. 00 Subtotal (see instructions) 33. 00 Subtotal (see instructions) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	12 00		)		0.000000	12 00
15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   16.0						•
instructions)  Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)  17.00 Cost of physicians' services in a teaching hospital (see instructions)  18.00 Direct graduate medical education payments (from Worksheet E-4, line 49)  19.00 Cost of covered services (sum of lines 6, 17 and 18)  20.00 Deductibles (exclude professional component)  21.00 Excess reasonable cost (from line 16)  22.134,082 19.00  23.00 Subtotal (line 19 minus line 20 and 21)  23.00 Coinsurance  24.00 Subtotal (line 22 minus line 23)  25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  26.00 Adjusted reimbursable bad debts (see instructions)  28.00 Subtotal (sum of lines 24 and 25, or line 26)  29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  10.00 Subtotal (see instructions)  29.00 Subtotal (see instructions)  29.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29.00 Subtotal (see instructions)  20.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  20.00 Subtotal (see instructions)			() (	-		
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   16.00   17	15.00					15.00
17.00   Cost of physicians' services in a teaching hospital (see instructions)   0   17.00   18.00   18.00   19.00	1/ 00					1/ 00
17.00	16.00		y it line 6 exceeds line	e 14) (See	U	16.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   18.00   Direct graduate medical education payments (from Worksheet E-4, line 49)   0   18.00   19.	17 00					17 00
18. 00   Direct graduate medical education payments (from Worksheet E-4, line 49)   19. 00   19. 00   Cost of covered services (sum of lines 6, 17 and 18)   2, 134, 082   19. 00   20. 00   Deductibles (exclude professional component)   277, 101   20. 00   21. 00   Excess reasonable cost (from line 16)   0   21. 00   22. 00   Subtotal (line 19 minus line 20 and 21)   1, 856, 981   22. 00   23. 00   Coinsurance   976   23. 00   24. 00   25. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   87, 881   25. 00   27. 00   Allowable bad debts (see instructions)   87, 881   25. 00   27. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   87, 881   27. 00   29. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   29. 00   29. 50   Pioneer ACO demonstration payment adjustment (see instructions)   1, 913, 128   28. 00   29. 99   Recovery of Accelerated Depreciation   32, 263   30. 01   30. 00   Subtotal (see instructions)   38, 263   30. 01   30. 00   30. 01   Sequestration adjustment (see instructions)   38, 263   30. 01   31. 00   Tentative settlement (for contractor use only)   33. 00   Balance due provider/program (line 30 minus lines 30. 01, 31, and 32)   -153, 714   33. 00   70. 00	17.00					
19.00       Cost of covered services (sum of lines 6, 17 and 18)       2, 134,082       19.00         20.00       Deductibles (exclude professional component)       277,101       20.00         21.00       Excess reasonable cost (from line 16)       0       21.00         22.00       Subtotal (line 19 minus line 20 and 21)       1,856,981       22.00         23.00       Coinsurance       976       23.00         24.00       Subtotal (line 22 minus line 23)       1,856,005       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       87,881       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       57,123       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       87,881       25.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,913,128       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.99       Recovery of Accelerated Depreciation       0       29.99         30.00       Subtotal (see instructions)       38,263       30.01         31.00       Interim payments       2,028,579       31.00         32.00       Tentative settlement	40.00		4 1 40		0	40.00
20. 00       Deductibles (exclude professional component)       277, 101       20. 00         21. 00       Excess reasonable cost (from line 16)       0       21. 00         22. 00       Subtotal (line 19 minus line 20 and 21)       1, 856, 981       22. 00         23. 00       Coinsurance       976       23. 00         24. 00       Subtotal (line 22 minus line 23)       1, 856, 005       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       87, 881       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       57, 123       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       87, 881       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 913, 128       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 50         29. 99       Recovery of Accelerated Depreciation       1, 913, 128       30. 00         30. 01       Sequestration adjustment (see instructions)       38, 263       30. 01         31. 00       Interim payments       2, 028, 579       31. 00			4, TTNe 49)			
21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   1,856,981   22.00   23.00   Coinsurance   976   23.00   24.00   Subtotal (line 22 minus line 23)   1,856,005   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   1,856,005   24.00   25.00   Allowable bad debts (exclude bad debts (see instructions)   57,123   26.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   87,881   27.00   28.00   Subtotal (sum of lines 24 and 25, or line 26)   1,913,128   28.00   29.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   29.00   29.50   Pioneer ACO demonstration payment adjustment (see instructions)   0,29,99   Recovery of Accelerated Depreciation   0,29,99   29.90		· · · · · · · · · · · · · · · · · · ·				•
22. 00       Subtotal (line 19 minus line 20 and 21)       1,856,981       22.00         23. 00       Coinsurance       976       23.00         24. 00       Subtotal (line 22 minus line 23)       1,856,005       24.00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       87,881       25.00         26. 00       Adjusted reimbursable bad debts (see instructions)       57,123       26.00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       87,881       27.00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1,913,128       28.00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29. 99       Recovery of Accelerated Depreciation       0       29.99         30. 00       Subtotal (see instructions)       1,913,128       30.00         30. 01       Sequestration adjustment (see instructions)       38,263       30.01         31. 00       Interim payments       2,028,579       31.00         32. 00       Tentative settlement (for contractor use only)       0       32.00         -153,714						
23. 00   Coinsurance   976   23. 00   24. 00   Subtotal (line 22 minus line 23)   1,856,005   24. 00   25. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   87,881   25. 00   27. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   87,881   25. 00   27. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   87,881   25. 00   27. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   87,881   27. 00   29. 00   29. 00   0.00		, , ,				•
24.00       Subtotal (line 22 minus line 23)       1,856,005       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       87,881       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       57,123       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       87,881       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,913,128       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.99       Recovery of Accelerated Depreciation       0       29.99         30.01       Subtotal (see instructions)       1,913,128       30.00         30.01       Interim payments       38,263       30.01         32.00       Tentative settlement (for contractor use only)       2,028,579       31.00         33.00       Balance due provider/program (line 30 minus lines 30.01, 31, and 32)       -153,714       33.00         -153,714       33.00						1
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  26. 00 Adjusted reimbursable bad debts (see instructions)  27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pioneer ACO demonstration payment adjustment (see instructions)  29. 99 Recovery of Accelerated Depreciation  30. 01 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  31. 00 Interim payments  32. 00 Tentative settlement (for contractor use only)  33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
26. 00 Adjusted reimbursable bad debts (see instructions)  27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 99 Recovery of Accelerated Depreciation  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 01 Interim payments  Tentative settlement (for contractor use only)  32. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 99 Recovery of Accelerated Depreciation  30. 01 Sequestration adjustment (see instructions)  30. 01 Sequestration adjustment (see instructions)  31. 00 Interim payments  Tentative settlement (for contractor use only)  32. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  87, 881 27. 00  1, 913, 128 28. 00  29. 90  29. 90  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 99  1, 913, 128 30. 00  29. 90  1, 913, 128 28. 00  29. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  20. 90  2			ces) (see instructions)			1
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.99 Recovery of Accelerated Depreciation 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 32.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39.00 Tentative settlement (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 39.00 Tentative settlement (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					· ·	l
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29.50 Pi oneer ACO demonstration payment adjustment (see instructions)  29.99 Recovery of Accelerated Depreciation  30.00 Subtotal (see instructions)  30.01 Sequestration adjustment (see instructions)  31.00 Interim payments  32.00 Tentative settlement (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,	ructions)		· ·	l
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 99 Recovery of Accelerated Depreciation Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 29. 50 29. 99 1, 913, 128 30. 00 38, 263 30. 01 2, 028, 579 31. 00 32. 00 -153, 714 33. 00 34. 00						
29. 99 Recovery of Accelerated Depreciation 0 29. 99 30. 00 Subtotal (see instructions) 1, 913, 128 30. 00 30. 01 Sequestration adjustment (see instructions) 38, 263 30. 01 31. 00 Interim payments 2, 028, 579 31. 00 32. 00 Tentative settlement (for contractor use only) 0 32. 00 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 31, and 32) -153, 714 33. 00 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00		, , , , ,				
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.00 38, 263 30.01 2, 0028, 579 31.00 0 32.00 0 32.00 0 33.00 0 34.00			s)		-	1
30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 38, 263 30.01 2,028,579 31.00 32.00 -153,714 33.00 34.00		,			-	
31.00 Interim payments  2,028,579 31.00 32.00 Tentative settlement (for contractor use only)  33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 34.00						l
32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 32.00 -153,714 33.00 34.00		, ,				
33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32)  -153,714 33.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  0 34.00						
34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
						ł
§115. 2	34.00		nce with CMS Pub. 15-2, o	chapter 1,	0	34.00
		§115. 2				

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

oni y)				12/01/2010	5/30/2017 11:	41 am_
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	11.00	2.00	0. 00	00	
1.00	Cash on hand in banks	1, 640, 467	1	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	5, 582, 882	0	0	0	3. 00 4. 00
5.00	Other recei vable	-428, 718	1	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0	1 _	0	Ö	6. 00
7.00	Inventory	271, 190	0	0	0	7. 00
8.00	Prepai d expenses	23, 683, 914	1	0	0	8. 00
9.00	Other current assets	3, 310, 031	1	0	0	9. 00
10. 00 11. 00	Due from other funds	-21, 756, 549	1	0	0	10. 00 11. 00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	12, 303, 217		U	0	11.00
12. 00	Land	985, 290	0	0	0	12. 00
13. 00	Land improvements	0		0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	20, 662, 927	1	0	0	15. 00
16.00	Accumulated depreciation	-8, 265, 707	1	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	3, 778	0	0	0	17. 00 18. 00
19. 00	Fi xed equipment	117, 827	_	0	Ö	19. 00
20. 00	Accumulated depreciation	-40, 645	1	0	0	20. 00
21. 00	Automobiles and trucks	23, 433	0	0	0	21. 00
22. 00	Accumul ated depreciation	-17, 265	1	0	0	22. 00
23. 00	Major movable equipment	2, 943, 814	1	0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-1, 630, 406	0	0	0	24. 00 25. 00
26. 00	Accumulated depreciation		0	0	0	26. 00
27. 00	HIT designated Assets	Ö	ő	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	14, 783, 046	0	0	0	30. 00
31. 00	OTHER ASSETS Investments	-22, 339	0	0	0	31. 00
32. 00	Deposits on Leases	-22, 339	0	0	0	32.00
33. 00	Due from owners/officers	Ö	ő	0	Ö	33. 00
34.00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	-22, 339	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	27, 063, 924	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	966, 480	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	498, 738	1	0	0	38.00
39. 00	Payroll taxes payable	0	ő	0	Ö	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43. 00 44. 00	Due to other funds Other current liabilities	1, 042, 621	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 507, 839		-	-	45. 00
10.00	LONG TERM LIABILITIES	2,00,,00,		<u> </u>	- C	10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0		0	0	47. 00
48. 00	Unsecured Loans	0 00 07/	0	0	0	48. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	25, 299, 976 25, 299, 976	1	0	0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	27, 807, 815			0	
000	CAPI TAL ACCOUNTS	27,007,010		<u> </u>	-	01100
52.00	General fund balance	-743, 891				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
56.00	Plant fund balance - invested in plant			U	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				Ö	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	-743, 891	1	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	27, 063, 924	0	0	0	60. 00
	• / /	I	I	ı l		ı

In Lieu of Form CMS-2552-10 Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1310 Peri od: Worksheet G-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/30/2017 11:41 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -6, 679, 153 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -11, 894, 834 2.00 3.00 Total (sum of line 1 and line 2) -18, 573, 987 0 3.00 4.00 0 Additions (credit adjustments) (specify) 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) -18, 573, 987 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -18, 573, 987 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00

0

0

0

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12. 00 13. 00

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16.00

17.00

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19.00

0

0

0

9.00

10.00

11.00

12.00

13. 00 14. 00

15. 00 16. 00

17.00

18.00

19.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

 
 Heal th Financial Systems
 PAR

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-1310

			То	12/31/2016	Date/Time Prep 5/30/2017 11:4	
	Cost Center Description	I npati ent		Outpati ent	Total	TT GIII
		1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1			2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal	2, 834, 8	390		2, 834, 890	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	49, (	000		49, 000	5. 00
6.00	Swing bed - NF	18, 3	280		18, 280	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)	2, 902,	170		2, 902, 170	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 lin	nes	0		0	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 902,			2, 902, 170	
18. 00	Ancillary services	6, 643, 2	227	83, 106, 271	89, 749, 498	18. 00
19. 00	Outpati ent servi ces		0	0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY			0	0	22. 00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )			222 //2	222 //2	25. 00
26. 00	HOSPI CE		0	832, 669	832, 669	
27. 00	OTHER (SPECIFY)		0	00 000 040	0 404 007	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 9, 545,	39 /	83, 938, 940	93, 484, 337	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			41, 163, 010		29. 00
30.00	ADD (SPECIFY)		0	41, 103, 010		30. 00
31.00	BAD DEBT	3, 582, 8	-			31. 00
32. 00	DAD DEDT	3, 302, 0	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)		Ŭ	3, 582, 837		36. 00
37. 00	DEDUCT (SPECIFY)		0	0,002,007		37. 00
38. 00	DEBOOT (OF ESTITI)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			Ō	ļ		41. 00
42. 00	Total deductions (sum of lines 37-41)			ol		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(1	transfer		44, 745, 847		43. 00
	to Wkst. G-3, line 4)					

		00.74		6.5	
	Financial Systems PARKVIEW WABASH HOS			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1310	Peri od: From 01/01/2016	Worksheet G-3	
			To 12/31/2016	Date/Time Pre	pared:
				5/30/2017 11:	41 am
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			93, 484, 337	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		61, 664, 412	ı
3.00	Net patient revenues (line 1 minus line 2)			31, 819, 925	ı
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		44, 745, 847	1
5.00	Net income from service to patients (line 3 minus line 4)			-12, 925, 922	5. 00
	OTHER INCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			248, 628	1
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			0	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			184, 794	
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		366, 752	
17. 00	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts			0	1 .0.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			77, 912	•
23. 00	Governmental appropriations			0	20.00
24. 00	GAIN ON DISPOSAL OF ASSETS			2, 271	24. 00

150, 731 1, 031, 088 -11, 894, 834

0 27. 00 0 28. 00 -11, 894, 834 29. 00

24. 01 25. 00 26. 00

24.00 GAIN ON DISPOSAL OF ASSETS
24.01 COUNTY AMBULANCE SERVICE GRANT
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)

	Fi xtures					1
2.00	Capital Related - Movable	0	0	0	0	2. 00
	Equi pment					1
3.00	Plant Operation & Maintenance	0	0	0	0	3. 00
4.00	Transportati on	0	0	0	0	4.00
5.00	Administrative and General	0	236, 261	0	236, 261	5. 00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	179, 742	0	179, 742	6. 00
7.00	Physi cal Therapy	0	164, 540	0	164, 540	7. 00
8.00	Occupati onal Therapy	0	21, 788	0	21, 788	8. 00
9.00	Speech Pathology	0	0	0	0	9. 00
10.00	Medical Social Services	0	45	0	45	10.00
11.00	Home Health Aide	0	94, 362	0	94, 362	11. 00
12.00	Supplies (see instructions)	0	37, 481	0	37, 481	12. 00
13.00	Drugs	0	4, 010	0	4, 010	13. 00
14.00	DME	0	0	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15. 00
16.00	Respiratory Therapy	0	0	0	0	16. 00
17.00	Private Duty Nursing	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0	0	21. 00
22. 00	Homemaker Service	0	0	0	0	22. 00
23.00	All Others (specify)	0	0	0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	738, 229	0	738, 229	24. 00

Heal th	Financial Systems	P.A	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der C		Peri od:	Worksheet H-1	
				HHA CCN:	15-7061	From 01/01/2016 To 12/31/2016		nared:
				Tillia Coll.	15 7001	10 12/31/2010	5/30/2017 11:	41 am
						Home Health	PPS	
					,	Agency I		
		Capital Rel	ated Costs					
		Bl dgs &	Movable	Plant		nReconciliation		
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	3.00	
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures	_						
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C		0		3. 00
4.00	Transportation (see	0	0	C	)	0		4. 00
	instructions)							
5.00	Administrative and General	0	0	C	)	0 -236, 261	501, 968	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C	)	0	179, 742	6. 00
7. 00	Physi cal Therapy	0	0	C	)	0 0	164, 540	
8. 00	Occupational Therapy	0	0	C	)	0	21, 788	
9.00	Speech Pathology	0	0		)	0	0	9.00
10.00	Medical Social Services	0	0		)	0	45	
11.00	Home Heal th Ai de	0	0		)	0		11.00
12.00	Supplies (see instructions)	0	0		2	0		12.00
13.00	Drugs DME	0	0	1	)	0		13.00
14. 00	HHA NONREI MBURSABLE SERVI CES	1 0	0	1	ή	0	0	14. 00
15. 00	Home Dialysis Aide Services		0		N .		0	15. 00
16. 00	Respiratory Therapy	1					0	16. 00
17 00		1					0	

0.000000

0

0.000000

0.000000

-236, 261

0. 000000

17.00

18.00

19.00 20. 00

21.00

22.00

23. 00

23.50

24.00

25.00

501, 968

236, 261

0. 470669 26. 00

Private Duty Nursing

Homemaker Service All Others (specify)

25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Telemedicine Total (sum of lines 1-23)

Health Promotion Activities Day Care Program Home Delivered Meals Program

Clinic

17.00 18.00

19.00

20.00

21.00

22. 00

23.00

23.50

24.00

Health Financial Systems PARKVI ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/30/2017 11:41 am Provider CCN: 15-1310 Peri od: From 01/01/2016 To 12/31/2016 HHA CCN: 15-7061 Home Health PPS

						Agency I	PPS	
			CAPITAL REL	ATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1. 00	2.00	4. 00	4A	5. 00	
1. 00	Administrative and General	0	7, 794	0	190, 140	197, 934	86, 065	1. 00
2.00	Skilled Nursing Care	264, 342	0	0	0	264, 342		2. 00
3.00	Physi cal Therapy	241, 984	0		0	241, 984		3. 00
4.00	Occupational Therapy	32, 043	0	1	0	32, 043	1	4.00
5. 00 6. 00	Speech Pathology Medical Social Services	0 66	0	0	0	66	0 29	5. 00 6. 00
7. 00	Home Heal th Aide	138, 775	0	Ö	0	138, 775	1	7. 00
8.00	Supplies (see instructions)	55, 122	0	0	0	55, 122		8. 00
9.00	Drugs	5, 897	0	0	0	5, 897	2, 564	9. 00
10.00	DME	0	0		0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services	0	0	· ·	0	0	0	11. 00 12. 00
13. 00	Respiratory Therapy Private Duty Nursing	0	0		] 0 0	0	0	13. 00
14. 00	Clinic	Ö	0	Ö	Ö	0	Ö	14. 00
15.00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	Ō	0	0	o	19. 50
20. 00	Total (sum of lines 1-19) (2)	738, 229	7, 794	0	190, 140			
21. 00	Unit Cost Multiplier: column					0. 000000		21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		7. 00	8. 00	9. 00	10.00	11.00	13.00	
1. 00	Administrative and General	50, 955	0		0	0	0	
2.00	Skilled Nursing Care	0	0		_	0	1	2.00
3. 00 4. 00	Physical Therapy Occupational Therapy	0	0	0	0	0	0	3. 00 4. 00
5.00	Speech Pathology	0	0	0	0	0	o o	5. 00
6.00	Medical Social Services	0	0	0	0	0	o	6. 00
7.00	Home Health Aide	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0		_	0	0	11. 00
12. 00	Respiratory Therapy	0	0	l	0	0	o	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	[ 0	0	0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0	0	·	0	0	0	
18. 00	Homemaker Servi ce	0	0		0	0	o	18.00
19. 00	All Others (specify)	0	0	·	0	0	o	19. 00
19. 50	Tel emedi ci ne	0	0		0	0	0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	50, 955	0	24, 231	0	0	l o	20. 00 21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.			l	I		I	l
				•				

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

	TITION OF OFFICE OFFICE		KKVILW WADASHII		011 45 4040		u 01 101111 0113-2	1002 10
ALLOC	ATION OF GENERAL SERVICE COSTS	IO HHA COSI CEN	IERS	Provider Co	CN: 15-1310 15-7061	Peri od: From 01/01/2016 To 12/31/2016		
						Home Health Agency I	PPS	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14. 00	15. 00	16. 00	24.00	25.00	26. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	1, 751 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	000000000000000000000000000000000000000	360, 9 379, 2 347, 2 45, 9	36       0         81       0         03       0         76       0         0       0         955       0         17       0         90       0         61       0         0       0	360, 936 379, 281 347, 203 45, 976 0 955 199, 117 79, 090 8, 461 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00 19. 00 19. 00 20. 00 21. 00
	Cost Center Description	Allocated HHA A&G (see Part	Total HHA Costs					
		27. 00	28. 00					
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	129, 243 118, 311 15, 667 0 322 67, 850 26, 950 2, 883 0 0 0 0 0 0 0 0 0 0 360, 936 0. 340755	508, 524 465, 514 61, 643 0 127 266, 967 106, 040 11, 344 0 0 0 0 0 0 0 0 0 0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

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

Peri od: Worksheet H-2
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/30/2017 11: 41 am

Home Health PPS BASIS HHA CCN: 15-7061

						Home Health	PPS	
		CAPITAL REI	ATED COSTS			Agency I		
		0,11,1,12,112	21122 00010					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMINISTRATIVE	OPERATION OF	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	PLANT	
				DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
				(GROSS				
		1.00	2. 00	SALARI ES) 4. 00	5A	5. 00	7. 00	
1. 00	Administrative and General	2, 175	0				2, 175	1. 00
2.00	Skilled Nursing Care	0	0			· ·	0	2.00
3.00	Physical Therapy	0	0	c			0	3.00
4.00	Occupational Therapy	0	0	C	) (	32, 043	0	4.00
5.00	Speech Pathology	0	0	C	)	0	0	5.00
6.00	Medical Social Services	0	0	C	) (	66	0	6.00
7.00	Home Health Aide	0	0		) (	,	0	7. 00
8. 00	Supplies (see instructions)	0	0	_			0	8. 00
9.00	Drugs	0	0			5, 897	0	9. 00
10.00	DME	0	0	_			0	10.00
11. 00 12. 00	Home Dialysis Aide Services	0	0	_			0	11. 00 12. 00
13. 00	Respiratory Therapy Private Duty Nursing		0				0	13. 00
14. 00	Clinic		0	_			0	14. 00
15. 00	Health Promotion Activities	0	0				0	15. 00
16. 00	Day Care Program	0	0	_		ol ol	0	16. 00
17. 00	Home Delivered Meals Program	0	0	d		ol ol	0	17. 00
18. 00	Homemaker Service	0	0	C		o	0	18.00
19.00	All Others (specify)	0	0	c	) (	o o	0	19.00
19. 50	Tel emedi ci ne	0	0	C	) (	0	0	19. 50
20. 00	Total (sum of lines 1-19)	2, 175	0	620, 577	1	936, 163	2, 175	20.00
21. 00	Total cost to be allocated	7, 794	0	190, 140	1	407, 059	50, 955	21. 00
22. 00	Unit cost multiplier	3. 583448	0. 000000			0. 434816	23. 427586	22. 00
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL SERVI CES &	
		(POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	ADMI NI STRATI ON	SUPPLY	
		LAUNDR)				(DIRECT NRSING	(COSTED	
						HR)	REQUIS.)	
		8. 00	9. 00	10.00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	2, 175		1	-	14, 264	1. 00
2.00	Skilled Nursing Care	0	0	C		0	0	2. 00
3.00	Physi cal Therapy	0	0			0	0	3. 00
4.00	Occupational Therapy	0	0				0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0				0	5. 00 6. 00
7. 00	Home Heal th Aide		0				0	7. 00
8. 00	Supplies (see instructions)	0	0	_			0	8. 00
9. 00	Drugs	0	0			ol ol	Ö	9. 00
10.00	DME	0	0	d		ol	0	10.00
11. 00	Home Dialysis Aide Services	0	0	c		o	0	11.00
12.00	Respiratory Therapy	0	0	c c	) (	o	0	12.00
13.00	Private Duty Nursing	0	0	C	) (	0	0	13.00
14. 00	1	0	0	C	) (	이	0	14.00
15. 00	Health Promotion Activities	0	0	C	)	0	0	15. 00
16.00	Day Care Program	0	0			0	0	16. 00
17.00	Home Delivered Meals Program	0	0				0	17.00
18. 00 19. 00	Homemaker Service		0				0	18. 00 19. 00
19. 00	All Others (specify) Telemedicine		0				0	19. 00
20. 00	Total (sum of lines 1-19)		2, 175				14, 264	20.00
21. 00	Total cost to be allocated		24, 231	l .		ol ol	1, 751	21. 00
22. 00	Unit cost multiplier	0. 000000			0.00000	0. 000000	0. 122757	
	•			,				

Health Financial Systems	P	ARKVIEW WABASH HO	SPITAL INC		In lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS			Provi der CC	CN: 15-1310	Peri od: From 01/01/2016	Worksheet H-2	
BASIS			HHA CCN:	15-7061	To 12/31/2016		pared: 41 am
					Home Health Agency I	PPS	
Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REV)					
	15 00	16 00					

Cost Center Description				Agency I	
REOUIS.   LIBRARY (GROSS REV)   15.00   16.00     1.00	Cost Center Description	PHARMACY	MEDI CAL		
1.00   Administrative and General   15.00   16.00			RECORDS &		
15.00		REQUIS.)			
1.00       Administrative and General       0       0         2.00       Skilled Nursing Care       0       0         3.00       Physical Therapy       0       0         4.00       Occupational Therapy       0       0         5.00       Speech Pathology       0       0         6.00       Medical Social Services       0       0         7.00       Home Health Aide       0       0         8.00       Supplies (see instructions)       0       0         9.00       Drugs       0       0         10.00       DME       0       0         11.00       Home Dialysis Aide Services       0       0         10.00       DME       0       0         11.00       Home Dialysis Aide Services       0       0         10.00       Despiratory Therapy       0       0         12.00       Respiratory Therapy       0       0         13.00       Private Duty Nursing       0       0         15.00       Health Promotion Activities       0       0         16.00       Day Care Program       0       0         17.00       Home Delivered Meals Program       0					
2.00       Skilled Nursing Care       0       0         3.00       Physical Therapy       0       0         4.00       Occupational Therapy       0       0         5.00       Speech Pathology       0       0         6.00       Medical Social Services       0       0         7.00       Home Health Aide       0       0         8.00       Supplies (see instructions)       0       0         9.00       Drugs       0       0         10.00       DME       0       0         11.00       Home Dialysis Aide Services       0       0         12.00       Respiratory Therapy       0       0         13.00       Private Duty Nursing       0       0         14.00       Clinic       0       0         15.00       Health Promotion Activities       0       0         15.00       Day Care Program       0       0         16.00       Day Care Program       0       0         17.00       Home Deli vered Meals Program       0       0         18.00       0       0       17.00         19.50       0       0       19.50         <		15. 00	16. 00		
3.00   Physical Therapy   0   0   0   0   0   0   0   0   0	l l	0	0		
4.00 Occupational Therapy 0 0 0 5.00 Speech Pathology 0 0 0 5.00 Speech Pathology 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9	0	0		
5. 00       Speech Pathology       0       0       5. 00         6. 00       Medical Social Services       0       0       6. 00         7. 00       Home Health Aide       0       0       7. 00         8. 00       Supplies (see instructions)       0       0       8. 00         9. 00       Drugs       0       0       9. 00         10. 00       DME       0       0       10. 00         11. 00       Home Dialysis Aide Services       0       0       11. 00         12. 00       Respiratory Therapy       0       0       11. 00         13. 00       Private Duty Nursing       0       0       12. 00         14. 00       Clinic       0       0       13. 00         14. 00       Health Promotion Activities       0       0       15. 00         16. 00       Day Care Program       0       0       15. 00         17. 00       Home Delivered Meals Program       0       0       17. 00         18. 00       Homemaker Service       0       0       18. 00         19. 50       Tel emedicine       0       0       19. 50         20. 00       Total (sum of lines 1-19)       0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0		
6.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	'	0	0		4.00
7.00 Home Heal th Aide	5.00 Speech Pathology	0	0		5. 00
8.00 Supplies (see instructions) 0 0 0 9.00 10.00 Drugs 0 0 0 0 10.00 DME 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 11.00 Respiratory Therapy 0 0 13.00 Private Duty Nursing 0 0 14.00 Clinic 0 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 0 0 16.00 Day Care Meals Program 0 0 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 18.00 Homemaker Service 0 0 19.50 Telemedicine 0 0 0 19.50 Telemedicine 0 0 0 19.50 Total (sum of lines 1-19) 0 0 10.00 Total (sum of lines 1-19) 0 0 10.00 Total cost to be allocated 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00 Medical Social Services	0	0		6. 00
9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Home Delivered Meals Program 19.00 All Others (specify) 19.00 All Others (specify) 19.50 Telemedicine 10.00 Total (sum of lines 1-19) 10.00 Total cost to be allocated	7.00 Home Health Aide	0	0		7. 00
10. 00 DME 11. 00 Home Dialysis Aide Services 0 0 0 0 11. 00 12. 00 Respiratory Therapy 0 0 0 12. 00 13. 00 Pri vate Duty Nursing 0 0 0 13. 00 15. 00 Heal th Promotion Activities 0 0 0 0 15. 00 16. 00 Day Care Program 0 0 0 0 17. 00 18. 00 Home Delivered Meals Program 0 0 0 0 17. 00 18. 00 Homemaker Service 0 0 0 0 18. 00 19. 00 All Others (specify) 19. 00 Tel emedicine 0 0 0 0 0 19. 50 20. 00 Total (sum of lines 1-19) 0 0 Total cost to be allocated	8.00 Supplies (see instructions)	0	0		8. 00
11. 00       Home Dialysis Aide Services       0       0         12. 00       Respiratory Therapy       0       0         13. 00       Private Duty Nursing       0       0         14. 00       Clinic       0       0         15. 00       Heal th Promotion Activities       0       0         16. 00       Day Care Program       0       0         17. 00       Home Delivered Meals Program       0       0         18. 00       Homemaker Service       0       0         19. 00       All Others (specify)       0       0         19. 50       Tel emedicine       0       0         20. 00       Total (sum of lines 1-19)       0       0         21. 00       Total cost to be allocated       0       0	9. 00 Drugs	0	0		9. 00
12.00       Respiratory Therapy       0       0       12.00         13.00       Private Duty Nursing       0       0       13.00         14.00       Clinic       0       0       14.00         15.00       Heal th Promotion Activities       0       0       15.00         16.00       Day Care Program       0       0       16.00         17.00       Home Delivered Meals Program       0       0       17.00         18.00       Homemaker Service       0       0       18.00         19.00       All Others (specify)       0       0       19.00         19.50       Tel emedicine       0       0       19.50         20.00       Total (sum of lines 1-19)       0       0       20.00         21.00       Total cost to be allocated       0       0       21.00	10. 00 DME	0	0		10.00
13.00     Private Duty Nursing     0     0       14.00     Clinic     0     0       15.00     Health Promotion Activities     0     0       16.00     Day Care Program     0     0       17.00     Home Delivered Meals Program     0     0       18.00     Homemaker Service     0     0       19.00     All Others (specify)     0     0       19.50     Tel emedicine     0     0       20.00     Total (sum of lines 1-19)     0     0       21.00     Total cost to be allocated     0     0	11.00 Home Dialysis Aide Services	0	0		11. 00
14.00     Clinic     0     0       15.00     Health Promotion Activities     0     0       16.00     Day Care Program     0     0       17.00     Home Delivered Meals Program     0     0       18.00     Homemaker Service     0     0       19.00     All Others (specify)     0     0       19.50     Telemedicine     0     0       20.00     Total (sum of lines 1-19)     0     0       21.00     Total cost to be allocated     0     0	12.00 Respiratory Therapy	0	0		12.00
15. 00	13.00 Private Duty Nursing	0	0		13.00
16.00     Day Care Program     0     0       17.00     Home Delivered Meals Program     0     0       18.00     Homemaker Service     0     0       19.00     All Others (specify)     0     0       19.50     Tel emedicine     0     0       20.00     Total (sum of lines 1-19)     0     0       21.00     Total cost to be allocated     0     0	14.00 Clinic	0	0		14.00
17. 00     Home Delivered Meals Program     0     0       18. 00     Homemaker Service     0     0       19. 00     All Others (specify)     0     0       19. 50     Tel emedicine     0     0       20. 00     Total (sum of lines 1-19)     0     0       21. 00     Total cost to be allocated     0     0	15.00   Health Promotion Activities	0	0		15. 00
18. 00     Homemaker Service     0     0     18. 00       19. 00     All Others (specify)     0     0     19. 00       19. 50     Tel emedicine     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     20. 00       21. 00     Total cost to be allocated     0     0     21. 00	16.00 Day Care Program	0	O		16. 00
19.00     All Others (specify)     0     0       19.50     Tel emedicine     0     0       20.00     Total (sum of lines 1-19)     0     0       21.00     Total cost to be allocated     0     0	17.00 Home Delivered Meals Program	0	O		17. 00
19. 50     Tel emedicine     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     20. 00       21. 00     Total cost to be allocated     0     0     21. 00	18.00 Homemaker Service	0	O		18. 00
19.50     Tel emedicine     0     0       20.00     Total (sum of lines 1-19)     0     0       21.00     Total cost to be allocated     0     0	19.00 All Others (specify)	0	O		19. 00
21.00 Total cost to be allocated 0 0 21.00		0	O		19. 50
21.00 Total cost to be allocated 0 0 21.00	20.00 Total (sum of lines 1-19)	0	O		20.00
22.00 Unit cost multiplier 0.000000 0.000000 22.00		0	O		21. 00
	22.00 Unit cost multiplier	0. 000000	0. 000000		22. 00

	<u>Financial Systems</u> FIONMENT OF PATLENT SERVICE COST		ARKVIEW WABASH			Peri od:	u of Form CMS-2 Worksheet H-3	
				HHA CCN:		From 01/01/2016 To 12/31/2016	Part I Date/Time Prep 5/30/2017 11:4	pared: 41 am
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols.	1	Per Visit (col. 3 ÷ col.	
		COI. 28, 1111e	H-2, Part I)	Part II)	+ 2)		(COI. 3 ÷ COI. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	ITATION COST, OF	}	
	BENEFICIARY COST LIMITATION							-
1. 00	Cost Per Visit Computation Skilled Nursing Care	2.00	508, 524		508, 52	2, 627	193. 58	1.00
2. 00	Physical Therapy	3. 00		0			284. 72	
3.00	Occupational Therapy	4. 00			1	· ·	192. 63	
4.00	Speech Pathology	5. 00	0	0	)	0 73	0. 00	4. 00
5.00	Medical Social Services	6. 00			12		42. 33	
6.00	Home Heal th Aide	7. 00			266, 96		99. 95	
7. 00	Total (sum of lines 1-6)		1, 302, 775	0				7. 00
			I		Program Visit	<u>s</u> ırt B		_
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	cost conten bescription	OOST ETHIN ES	020/(110. (1)	rui t A	Deducti bles			
					Coi nsurance			
		0	1.00	2. 00	3. 00	4. 00	5. 00	
0.00	Limitation Cost Computation	1	99915	0	J = 50	E		0.00
8. 00 9. 00	Skilled Nursing Care Physical Therapy	1	99915					8. 00 9. 00
10.00	Occupational Therapy		99915	0				10.00
11. 00	Speech Pathology		99915	Ö	1	2		11. 00
12.00	Medical Social Services		99915	0	)	1		12. 00
13.00	Home Health Aide		99915	0		1		13. 00
14. 00	Total (sum of lines 8-13)			0				14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Records)	÷ col. 4)	
		20, 11116	11-2, 141 (1)	Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
15. 00		8. 00					0. 000000	
16.00	Cost of Drugs	9. 00	11,344 Program Visits		11, 34 Cost of	4 0	0. 000000	16. 00
			Program visits		Servi ces			
			Par	t B	30. 1. 000	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	505			0 97, 758		1. 00
2.00	Physi cal Therapy	0				0 194, 179		2. 00
3.00	Occupational Therapy	0	119			0 22, 923		3.00
4. 00 5. 00	Speech Pathology Medical Social Services	0	22			0 0 42		4. 00 5. 00
6. 00	Home Heal th Ai de		11			0 1, 099		6. 00
7. 00	Total (sum of lines 1-6)	0	1			0 316, 001		7. 00
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
0.00	Limitation Cost Computation	ı						0.00
8. 00 9. 00	Skilled Nursing Care Physical Therapy							8. 00 9. 00
	Occupational Therapy							10.00
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	1		1			
10.00	Speech Pathology							11.00
	Speech Pathology Medical Social Services							11. 00 12. 00
10. 00 11. 00 12. 00 13. 00	Medical Social Services							

	Financial Systems TONMENT OF PATIENT SERVICE COST		ARKVIEW WABASH	Provider CO	N. 1E 1210	Peri od:	u of Form CMS-2 Worksheet H-3	
APPURI	TONMENT OF PATTENT SERVICE COST	5		Provider CC	JN: 15-1310	From 01/01/2016		
				HHA CCN:	15-7061	To 12/31/2016		
				Title	XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	irges	Cost of	, agency :		
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &	Deductibles & Coinsurance		Deductibles &	Deductibles &	
		6. 00	Coi nsurance 7.00	8. 00	9. 00	Coi nsurance 10.00	Coi nsurance 11.00	
	Supplies and Drugs Cost Computa		7.00	8.00	9.00	10.00	11.00	
15. 00	Cost of Medical Supplies	(	0	0		0 0	0	15. 00
	Cost of Drugs		1, 092			0	0	
	Cost Center Description	Total Program		-			-	
	·	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							-
1. 00	Cost Per Visit Computation Skilled Nursing Care	97, 758	,					1.00
2. 00	Physical Therapy	194, 179						2.00
3.00	Occupational Therapy	22, 923						3.00
4. 00	Speech Pathology	22, 720						4. 00
5. 00	Medical Social Services	42						5. 00
6.00	Home Health Aide	1, 099						6.00
7.00	Total (sum of lines 1-6)	316, 001						7.00
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy Speech Pathology							10.00
11. 00 12. 00	Speech Pathology   Medical Social Services							12.00
12.00	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
17.00	Trotal (Sum of Fries 6 15)	ı	I					1 17.00

Heal th	Financial Systems	PA	RKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der Co		Peri od:	Worksheet H-3	·
				HHA CCN:	15-7061	From 01/01/2016 To 12/31/2016		pared: 41 am
				Title	xVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 584992	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67. 00	0. 646304	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 000000	0		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 319962	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 347086	0		0 col. 2, line 1	6. 00	5. 00

th Financial Systems PARKVIEW WABASH HOSI ULATION OF HHA REIMBURSEMENT SETTLEMENT	PITAL, INC. Provider CO	N: 15-1310	Peri od:	wof Form CMS-2 Worksheet H-4	
SETTION OF THE MEDITAL MEDITAL SETTIEL MEDITAL	HHA CCN:	15-7061	From 01/01/2016 To 12/31/2016	Part I-II Date/Time Pre	epar
	Ti tl e	XVIII	Home Health	5/30/2017 11: PPS	41
			Agency I	t B	
		Part A	Not Subject to		
				Deductibles &	
			Coi nsurance	Coi nsurance	
DART L COMPUTATION OF THE LECCED OF DEACONABLE COST OR CHICAGO	MARY CHARCE	1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOR Reasonable Cost of Part A & Part B Services	WARY CHARGE	3			+
Reasonable cost of services (see instructions)			0 0	0	
Total charges			0 0	0	) :
Customary Charges					
Amount actually collected from patients liable for payment for	servi ces		0 0	0	) :
on a charge basis (from your records)  Amount that would have been realized from patients liable for	navmon+		0 0	0	) 4
for services on a charge basis had such payment been made in a					Ί΄
with 42 CFR §413. 13(b)					
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
Total customary charges (see instructions)			0 0	0	
Excess of total customary charges over total reasonable cost (	complete		0	0	)
only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl	vifline		0 0	0	,
1 exceeds line 6)	y i i iiie		0	١	1
Pri mary payer amounts			0 0	0	)
			Part A	Part B	
			Servi ces 1.00	Servi ces 2.00	+
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
O Total reasonable cost (see instructions)			0	0	1
O Total PPS Reimbursement - Full Episodes without Outliers			0	261, 648	
O Total PPS Reimbursement - Full Episodes with Outliers			0	0	
0   Total PPS Reimbursement - LUPA Episodes 0   Total PPS Reimbursement - PEP Episodes			0	2, 749 2, 460	
0   Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	2, 460	
O Total PPS Outlier Reimbursement - PEP Episodes			ő	ő	
O Total Other Payments			0	0	
O DME Payments			0	0	) 1
0 Oxygen Payments			0	0	
O Prosthetic and Orthotic Payments	ranga)		0	0	
O Part B deductibles billed to Medicare patients (exclude coinsu O Subtotal (sum of lines 10 thru 20 minus line 21)	i ance)		0	0 266, 857	
0 Excess reasonable cost (from line 8)			0	200, 837	1
0 Subtotal (line 22 minus line 23)			Ö	266, 857	
O Coinsurance billed to program patients (from your records)				0	1
0 Net cost (line 24 minus line 25)			0	266, 857	
O Reimbursable bad debts (from your records)					2
Reimbursable bad debts for dual eligible beneficiaries (see in				0// 0==	2
O  Total costs - current cost reporting period (line 26 plus line O  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	21)		0	266, 857 0	
O Pioneer ACO demonstration payment adjustment (see instructions	3)		0		
O Subtotal (see instructions)	,		0	l	
Sequestration adjustment (see instructions)			0	l	
O Interim payments (see instructions)			0	l	
O Tentative settlement (for contractor use only)			0	0	
					1 2
O Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordan			0	0	

Heal th Financial Systems PARKVIEW WABASH HOSPITAL, INC.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED

TO PROGRAM BENEFICIARIES

Provider C Provider CCN: 15-1310 Peri od: From 01/01/2016 To 12/31/2016 Worksheet H-5 Date/Time Prepared: 5/30/2017 11:41 am HHA CCN: 15-7061

				Home Health Agency I	PPS	+1 alli
		I npati en	t Part A		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 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	261, 520 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3.02				0	0	3.02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program		I	0	0	3. 50
3. 51				0		3. 50
3. 52				0	o o	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)			_		
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	261, 520	4. 00
	TO BE COMPLETED BY CONTRACTOR			<u>'</u>		
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U	U	5. 05
5. 50	Trovider to Trogram			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER				0	6. 00
6. 01 6. 02	SETTLEMENT TO PROGRAM			0	0	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)			0	261, 520	7. 00
7.00	1.01.0. mod. od. o program in ability (360 instructions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provider CCN: 15-1310 Peri od: From 01/01/2016 To 12/31/2016 Worksheet 0 Date/Time Prepared: 5/30/2017 11:41 am Hospi ce CCN: 15-1545

					11! 1	3/30/2017 11.	TI alli
		041.451.50	OTUED.	DUDTOTAL (	Hospi ce I	OURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00	0.00	1 plus col. 2)	CATI ONS	F 00	
	OFNEDAL CERVI OF COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FLXT*		0	0	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3. 00
4.00	ADMINISTRATIVE & GENERAL*	56, 712	116, 755	173, 467	0	173, 467	4.00
5.00	PLANT OPERATION & MAINTENANCE*	O	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	ol	0	o	0	0	6. 00
7. 00	HOUSEKEEPI NG*	0	0		0	0	7. 00
8.00	DI ETARY*	ا	0		0	0	8. 00
9. 00	NURSING ADMINISTRATION*	0	0		0	0	9. 00
	· ·	0	4 744	1 714	0	_	
10.00	ROUTINE MEDICAL SUPPLIES*	0	1, 714	1, 714	0	1, 714	10. 00
11. 00	MEDI CAL RECORDS*	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION*	0	15, 942	15, 942	0	15, 942	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	36, 605	36, 605	0	36, 605	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	ol	0	0	0	0	15. 00
16, 00	OTHER GENERAL SERVICE*	0	0		0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		· ·		Ö	Ŭ	17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS						17.00
25. 00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25. 00
		· ·	U	1	-		
26. 00	PHYSI CI AN SERVI CES**	0	Ü	0	0	0	26. 00
27. 00	NURSE PRACTITIONER**	3, 010	0	3, 010	0	3, 010	27. 00
28. 00	REGI STERED NURSE**	106, 058	0	106, 058	0	106, 058	28. 00
29. 00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	533	0	533	0	533	30.00
31.00	OCCUPATI ONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	ol	0	ol	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	37, 084	0	37, 084	0	37, 084	33. 00
34. 00	SPI RI TUAL COUNSELI NG**	0,700.	0	0.7,00.	0	0	34.00
35. 00	DI ETARY COUNSELI NG**	0	0		0	0	35. 00
36. 00	COUNSELING - OTHER**		0		0	0	36. 00
		۱	0	24 120	0		
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	34, 138	U	34, 138	0	34, 138	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	Ü	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION**	0	0	0	0	0	39. 00
40. 00	I MAGI NG SERVI CES**	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	ol	0	ol o	0	0	42. 00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0		0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	o o	0	o o	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**		0		0	0	46. 00
46.00	, ,	U U	U	ıj U	U	U	40.00
	NONREI MBURSABLE COST CENTERS				0	0	
60.00	BEREAVEMENT PROGRAM *	0	0	1	0	0	60.00
61. 00	VOLUNTEER PROGRAM *	0	0	0	0	0	61. 00
62.00	FUNDRAI SI NG*	0	0	0	0	0	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES*	ol	0	ol o	0	0	65. 00
66. 00	RESI DENTI AL CARE*	ام	0	ا ما	n	0	66. 00
67. 00	ADVERTI SI NG*	ام	n	) o	n	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		0	0	68. 00
	THRIFT STORE*		0		0	0	69.00
69. 00			0	(	0		
70.00	NURSING FACILITY ROOM & BOARD*	0	0	<u>[</u>	0	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0 ۔ ۔ ۔ ۔ ا	0	0	71. 00
100.00		237, 535	171, 016	408, 551	0	408, 551	100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5, col	lumn 1, line as	appropri ate.				

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/30/2017 11:41 am Hospi ce CCN: 15-1545 Hospi ce I

ENREMAL SERVICE COST CENTERS					Hospi ce I	
CAP REL COSTS-BLDG & FLXT"			ADJUSTMENTS	TOTAL (col. 5		
GINERAL SERVICE COST CHUTES   1.00   CAP REL COSTS-BUDG & FIXT*   0   0   1.00     2.00   CAP REL COSTS-SWELE EQUIP   0   0   0   2.00     3.00   EMPLOYER BENEFIT SEPARTMENT*   0   0   3.00     4.00   ADMINISTRATIVE & CENEFOL!   0   173,467   4.00     4.00   ADMINISTRATIVE & CENEFOL!   0   0   0     5.00   CADON STAND & CONTROL   0   0   0     7.00   ADMINISTRATIVE & CENEFOL!   0   0   0   0     8.00   DETARY*   0   0   0   0   0     9.00   NURSI NG ADMINISTRATION*   0   0   0   0     9.00   NURSI NG ADMINISTRATION*   0   0   0   11.00     10.00   ROTHER MEDICAL SUPPLIES*   0   1,714   10.00     11.00   ADMINISTRATION*   0   15,942   12.00     12.00   STAFE TRANSPORTATION*   0   15,942   12.00     13.00   VOLUNTEER SERVICE COORDINATION*   0   15,942   12.00     13.00   VOLUNTEER SERVICE COORDINATION*   0   15,942   12.00     13.00   VOLUNTEER SERVICE COORDINATION*   0   0   0     16.00   OTHER GENERAL SERVICES*   0   0   0     16.00   OTHER GENERAL SERVICES*   0   0   0     16.00   OTHER GENERAL SERVICES*   0   0   0     17.00   PATTE FAILER LIFE TAIL VE SERVICES   0   0   0     18.00   OTHER GENERAL SERVICES*   0   0   0     19.00   OTHER GENERAL SERVICES*   0   0   0     10.00   OTHER GE						
1.00			6. 00	7. 00		
2.00   CAP. REL. COSTS.JWELE EQUIP				_	I	
2.00   MIMICAVE BENEFITS DEPARTMENT*   0   0   0   0   0   0   0   0   0			0		1	1
ADMINISTRATIVE & CENERAL*   0   173,467   0   5.00			0		1	1
DIANT OPERATION & MAINTENANCE*   0			0		l .	1
AUMDRY & LINEN SERVICE*			0	173, 467		1
7, 00         HOUSEKEEPING*         0         0         8.00           9, 00         NURSING ADMINISTRATION*         0         0         9.00           10, 00         NURSING ADMINISTRATION*         0         0         9.00           11, 00         MEDICAL RECORDS*         0         0         11.00           12, 00         STAFT FRANSPORTATION*         0         15.00         13.00           13, 00         VOLUNTEER SERVI CE COORDINATION*         0         0         13.00           15, 00         PHYSI CI AN LAXIN IN STRATI VE SERVI CES*         0         0         15.00           16, 00         PHYSI CI AN LAXIN IN STRATI VE SERVI CES*         0         0         16.00           17, 00         PHYSI CI AN LAXIN IN STRATI VE SERVI CES*         0         0         16.00           17, 00         PHYSI CI AN LAXIN IN STRATI VE SERVI CES*         0         0         20         16.00           17, 00         PHYSI CI AN LAXIN IN STRATI VE SERVI CES*         0         0         20         17.00         16.00         17.00         18.00         17.00         17.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.00         18.0			0		l .	1
B. 00   DETARY*   0   0   0   9   00   0   0   0   0			0		1	1
9.00         NURSI NG ADMINISTRATION*         0         0         0         1.00         0         1.10         1.00         0         1.10         1.00         0         1.10         0         0         1.10         0         1.10         0         0         0         1.10         0			0	_	l .	1
10. 00   ROUTI NE NEDICAL SUPPLIES*   0   1,714   1.0 00   1.0 0			0	-	l .	
11. 00   MEDICAL RECORDS*   0   0   0   11. 00     12. 00   STAFF TRANSPORTATION*   0   15. 042   12. 00     13. 00   VOLUNTEER SERVICE COORDINATION*   0   0   0   0   13. 00     14. 00   PHYSI CIAN ADMINISTRATIVE SERVICES*   0   0   0   0   16. 00     15. 00   PHYSI CIAN ADMINISTRATIVE SERVICES*   0   0   0   0   16. 00     16. 00   OTHER GENERAL SERVICE*   0   0   0   0   16. 00     17. 00   PATIENTY CARE-CONTRACTED**   0   0   0   0     18. 00   DIRECT PATIENT CARE-SERVICE COST CENTERS   0   0   0     19. 00   DIRECT PATIENT CARE-CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   25. 00     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTRACTED**   0   0   0   0     10. 00   CONTROL OF CONTROL OF CONTRACTED OF CONTROL OF CONTRACTED OF CONTROL OF CONTRO			0	0		
12. 00   STAFF TRANSPORTATION*   0   15, 042   12. 00   13. 00   14. 00   PHARMACY*   0   36, 605   14. 00   15. 00   PHARMACY*   0   36, 605   15. 00   15. 00   PHARMACY*   0   0   0   0   0   15. 00   15. 00   15. 00   PHARMACY*   0   0   0   0   0   15. 00   15. 00   15. 00   0   0   0   0   0   0   0   0   0	10.00	ROUTINE MEDICAL SUPPLIES*	0	1, 714		10. 00
13. 00   VOLUNTEER SERVICE COORDINATION*   0   0   0   13. 00   15. 00   14. 00   15. 00   15. 00   15. 00   0   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   16. 0			0	·		
14. 00   PHARMACY*		· ·	0	15, 942		
15. 00   PHYSI CIAN ADMINISTRATIVE SERVICES* 0 0 0 0 16. 00 17. 00   PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 17. 00   PATIENT/RESIDENTIAL CARE SERVICE COST CENTERS	13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13. 00
16. 00   OTHER GENERAL SERVICE"   17. 00   17.	14.00	PHARMACY*	0	36, 605		14. 00
17. 00   PATI ENT_RESIDENTIAL CARE SERVICES	15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15. 00
DIRECT PATIENT CARE SERVICE COST CENTERS   0   0   0   25	16.00	OTHER GENERAL SERVICE*	0	0		16. 00
25. 00	17.00					17. 00
26. 00						
27. 00			0		i e	
28. 00   REGISTERED NURSE**	26.00	PHYSI CI AN SERVI CES**	0	0		26. 00
29.00   Physical Therapy**   0   0   0   33.00     30.00   Physical Therapy**   0   0   533   30.00     30.00   Speech/Language Pathology**   0   0   0     31.00   Occupational Therapy**   0   0   0     32.00   Speech/Language Pathology**   0   0   0     32.00   Speech/Language Pathology**   0   0   0     33.00   Medical Scriptices**   0   0   0     34.00   Spirit Tual Counseling**   0   0   0     35.00   Dietary Counseling**   0   0   0     36.00   Counseling*   Others*   0   0   0     37.00   Hospical English	27.00	NURSE PRACTITIONER**	0	3, 010		27. 00
30.00   DHYSI CAL THERAPY**   0   533   30.00   31.00   32.0	28. 00	REGI STERED NURSE**	0	106, 058		28. 00
31.00   OCCUPATIONAL THERAPY**   0   0   0   31.00	29. 00	LPN/LVN**	0	0		29. 00
32.00   SPEECH/LANGUAGE PATHOLOGY**   0 0 0 37,084   33.00     33.00   MEDI CAL SOCI AL SERVI CES**   0 37,084   33.00     33.00   MEDI CAL SOCI AL SERVI CES**   0 0 0 0   34,00       35.00   DI ETARY COUNSELI NG**   0 0 0 0   35.00       36.00   COUNSELI NG - OTHER**   0 0 0 0   36.00     37.00   HOSPI CE AI DE & HOMEMAKER SERVI CES**   0 34,138   37.00     38.00   DURABLE MEDI CAL EQUI PMENT/OXYGEN**   0 0 0   38.00     39.00   DURABLE MEDI CAL EQUI PMENT/OXYGEN**   0 0 0   39.00     40.00   IMAGI NG SERVI CES**   0 0 0   0   40.00     41.00   LABS & DI AGNOSTI CS**   0 0 0   41.00     42.00   MEDI CAL SUPUL ES-NON-ROUTI NE**   0 0 0   42.00     44.00   PALLI ATI VE RADI ATI ON THERAPY**   0 0 0   44.00     45.00   PALLI ATI VE REDI CAL SUPUL ES-NON-ROUTI NE**   0 0 0   45.00     46.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0   46.00     46.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   PALLI ATI VE CHEMOTHERAPY**   0 0 0   60.00     40.00   PALLI ATI VE CHEMOTHERAPY**   0 0 0   60.00     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0 0 0     40.00   OTHER SIDIES (SPECI FY)**   0 0 0     40.00   OTHER SIDIES (SPECI FY)**   0 0 0     40.00   OTHER SIDIES (SPECI FY)*   0 0 0     40.00   OTHER	30.00	PHYSI CAL THERAPY**	0	533		30. 00
33.00   MEDICAL SOCI AL SERVICES**   0   37,084   33.00   SPIR ITUAL COUNSELING**   0   0   0   0   34.00   35.00   DIETARY COUNSELING**   0   0   0   0   35.00   0   0   0   35.00   0   0   0   0   0   0   0   0   0	31.00	OCCUPATIONAL THERAPY**	0	0		31. 00
34. 00 35. 00 DI ETARY COUNSELING** 0 0 0 0 35. 00 0 DI ETARY COUNSELING** 0 0 0 0 36. 00 0 0 0 37. 00 HOSPICE AI DE & HOMEMAKER SERVICES** 0 0 0 0 34. 138 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		SPEECH/LANGUAGE PATHOLOGY**	0	0		32. 00
35. 00   DIETARY COUNSELING**   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	37, 084		
36. 00 COUNSELING - OTHER** 0 0 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 34,138 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 0 34,138 38. 00 DIARBLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 38. 00 9 PATI ENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1	•
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 34, 138 38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 38. 00 40. 0			0	-	1	•
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 39. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 40. 00 40. 00 IMAGING SERVICES** 0 0 0 40. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 42. 00 43. 00 OUTPATIENT SERVICES** 0 0 0 44. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 62. 00 63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 63. 00 65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 66. 00 66. 00 RESIDENTIAL CARE* 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING* 0 0 0 68. 00 69. 00 THIRIFT STORE* 0 0 0 0 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY)** 0 0 0 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY)** 0 0 0 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY)** 0 0 0 71. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY)** 0 0 71. 00			0		l .	•
39. 00 PATIENT TRANSPORTATION** 0 0 0 0 40. 00 40. 00 40. 00 1 MAGI NG SERVI CES** 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 0 42. 00 43. 00 0UTPATIENT SERVI CES** 0 0 0 0 43. 00 0UTPATIENT SERVI CES** 0 0 0 0 44. 00 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45. 00 9 44. 00 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		•	1
40. 00   IMAGI NG SERVI CES**		DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38. 00
41.00 LABS & DI AGNOSTI CS** 0 0 0 42.00 42.00 42.00 43.00 UTPATI ENT SERVI CES** 0 0 0 0 43.00 UTPATI ENT SERVI CES** 0 0 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 44.00 45.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45.00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 61.00 VOLUNTEER PROGRAM * 0 0 0 61.00 VOLUNTEER PROGRAM * 0 0 0 62.00 FUNDRAI SI NG* 0 0 0 63.00 HOSPI CE-/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64.00 66.00 PALLI ATI VE CARE PROGRAM* 0 0 0 66.00 66.00 RESI DENTI AL CARE* 0 0 0 66.00 RESI DENTI AL CARE* 0 0 0 66.00 RESI DENTI AL CARE* 0 0 0 0 67.00 68.00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 69.00 69.00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 00	PATI ENT TRANSPORTATI ON**	0	0		39. 00
42. 00   MEDI CAL SUPPLI ES-NON-ROUTI NE**   0   0   0   42. 00   43. 00   OUTPATI ENT SERVI CES**   0   0   0   43. 00   44. 00   PALLI ATI VE RADI ATI ON THERAPY**   0   0   0   45. 00   45. 00   PALLI ATI VE CHEMOTHERAPY**   0   0   0   45. 00   46. 00   OTHER PATIENT CARE SERVI CES (SPECI FY)**   0   0   0      NONREI MBURSABLE COST CENTERS   0   0   61. 00   61. 00   VOLUNTEER PROGRAM *   0   0   61. 00   62. 00   FUNDRAI SI NG*   0   0   62. 00   63. 00   HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*   0   0   63. 00   64. 00   PALLI ATI VE CARE PROGRAM*   0   0   64. 00   65. 00   OTHER PHYSI CI AN SERVI CES*   0   0   66. 00   66. 00   RESI DENTI AL CARE*   0   0   66. 00   67. 00   ADVERTI SI NG*   0   0   66. 00   68. 00   TELEHEALTH/TELEMONI TORI NG*   0   0   68. 00   69. 00   THIR IFT STORE*   0   0   0   70. 00   NURSI NG FACI LITY ROOM & BOARD*   0   0   71. 00   OTHER NONREI MBURSABLE (SPECI FY)*   0   0   71. 00   OTHER NONREI MBURSABLE (SPECI FY)*	40.00	I MAGI NG SERVI CES**	0	0		40. 00
43.00	41.00	LABS & DI AGNOSTI CS**	0	0		41. 00
44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 45. 00 45. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42. 00
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45. 00  46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00		0	0		43. 00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 46. 00  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00  61. 00 VOLUNTEER PROGRAM * 0 0 0 61. 00  62. 00 FUNDRAI SI NG* 0 0 0 63. 00  63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 63. 00  64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 64. 00  65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 65. 00  66. 00 RESI DENTI AL CARE* 0 0 0 66. 00  67. 00 ADVERTI SI NG* 0 0 67. 00  68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 68. 00  70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 70. 00  71. 00 OTHER NONREI MBURSABLE (SPECI FY)*	44.00	PALLIATIVE RADIATION THERAPY**	0	0		44. 00
NONREIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O	45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45. 00
60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00 61. 00 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 65. 00 66. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 GRESI DENTI AL CARE* 0 0 0 66. 00 ADVERTI SI NG* 0 0 66. 00 FLEHERALTH/TELEMONI TORI NG* 0 0 0 68. 00 TELEHERALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46.00		0	0		46. 00
61. 00						
62. 00 FUNDRAI SI NG* 0 0 0 63. 00 64. 00 63. 00 64. 00 9 ALLI ATI VE CARE PROGRAM* 0 0 0 64. 00 65. 00 0 65. 00 0 66. 00 66. 00 0 66. 00 66. 00 67. 00 68. 00 1 67. 00 68. 00 1 67. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 68. 00 1 69. 00					•	1
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 65. 00 66. 00 0 0 0 66. 00 65. 00 0 0 66. 00 65. 00 0 66. 00 66. 00 66. 00 66. 00 67. 00 0 0 67. 00 68. 00 0 0 67. 00 68. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0		•	1
64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 67. 00 67. 00 ADVERTI SI NG* 0 0 0 67. 00 68. 00 THRI FT STORE* 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*		1	0			•
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 68. 00 69. 00 68. 00 69. 00 68. 00 69. 00 68. 00 69. 00 69. 00 68. 00 69. 00 68. 00 69			0		i e	
66. 00 RESI DENTI AL CARE* 0 0 0 67. 00 67. 00 67. 00 68. 00 67. 00 68. 00 67. 00 68. 00 69. 00 68. 00 69.			0		i e	•
67. 00   ADVERTI SI NG*			0		i e	•
68.00   TELEHEALTH/TELEMONI TORI NG*   0 0 0   68.00   69.00   THRI FT STORE*   0 0 0   70.00   NURSI NG FACILITY ROOM & BOARD*   0 0   71.00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0   71.00   0   0   0   71.00   0   0   0   71.00   0   0   71.00   0   0   71.00   0   0   71.00   0   0   71.00   0   0   71.00   0   0   71.00   0			0		•	•
69.00 THRIFT STORE* 0 0 0 69.00 70.00 NURSING FACILITY ROOM & BOARD* 0 0 71.00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 71.00			0		•	1
70.00   NURSING FACILITY ROOM & BOARD*   0   0   70.00   71.00   0   0   71.00   0   0   0   0   0   0   0   0   0			0		•	•
71. 00   OTHER NONREI MBURSABLE (SPECI FY)* 0 0 71. 00			0		•	1
			0			1
100. 00  TOTAL   0  408, 551    100. 00			0	-	l .	
	100.00	IOIAL	0	408, 551		100. 00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems PARKVIEW WABASH ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME Provider CCN: 15-1310 Peri od: Worksheet 0-2 From 01/01/2016 To 12/31/2016 CARE Date/Time Prepared: 5/30/2017 11:41 am Hospi ce CCN: 15-1545

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2. 00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	INPATIENT CARE-CONTRACTED						25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	2, 975	0	2, 975	0	2, 975	27. 00
28.00	REGI STERED NURSE	104, 850	0	104, 850	0	104, 850	28. 00
29.00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	527	0	527	0	527	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	36, 661	0	36, 661	0	36, 661	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	33, 749	0	33, 749	0	33, 749	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42. 00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100.00	TOTAL *	178, 762	0	178, 762	0	178, 762	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.	5. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.	5. 00
27.00	NURSE PRACTITIONER	0	2, 975	27.	7. 00
28.00	REGI STERED NURSE	0	104, 850	28.	3. 00
29.00	LPN/LVN	0	0	29.	9. 00
30.00	PHYSI CAL THERAPY	0	527	30.	0. 00
31.00	OCCUPATI ONAL THERAPY	0	0	31.	1.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.	2. 00
33.00	MEDICAL SOCIAL SERVICES	0	36, 661	33.	3. 00
34.00	SPIRITUAL COUNSELING	0	0	34.	4. 00
35.00	DI ETARY COUNSELING	0	0	35.	5. 00
36.00	COUNSELING - OTHER	0	0	36.	5. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	33, 749	37.	7. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.	3. 00
39.00	PATIENT TRANSPORTATION	0	0	39.	9. 00
40.00	I MAGING SERVICES	0	0	40.	0. 00
41.00	LABS & DIAGNOSTICS	0	0	41.	1.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.	2. 00
43.00	OUTPATIENT SERVICES	0	0	43.	3. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.	4. 00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.	5. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.	5. 00
100.00	TOTAL *	0	178, 762	100.	0. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Provider CCN: 15-1310 Hospi ce CCN: 15-1545 Peri od: Worksheet 0-3 From 01/01/2016 Date/Time Prepared: 5/30/2017 11:41 am 12/31/2016 To

Hospi ce I SALARI ES OTHER SUBTOTAL (col. RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 PHYSICIAN SERVICES 0 0 26.00 0 0 0 0 0 0 0 0 0 0 0 0 26.00 NURSE PRACTITIONER 13 27.00 13 0 13 27.00 28.00 REGISTERED NURSE 445 0 445 445 28.00 29.00 LPN/LVN 0 0 29.00 0 2 0 30.00 PHYSI CAL THERAPY 2 2 30.00 OCCUPATIONAL THERAPY 0 0 0 31.00 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 156 156 156 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 0 0 0 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 37.00 37.00 143 143 143 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 0 39.00 IMAGING SERVICES 0 40.00 40.00 0 LABS & DIAGNOSTICS 0 0 0 0 0 41.00 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 44.00 PALLIATIVE CHEMOTHERAPY 0 45.00 45.00 0 0 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 C 0 0 0 46.00 100.00 TOTAL 759 759 100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26. 00
27.00	NURSE PRACTITIONER	0	13	27. 00
28.00	REGI STERED NURSE	0	445	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	2	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	156	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	143	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42. 00
43.00	OUTPATIENT SERVICES	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	759	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 15-1310 Hospi ce CCN: 15-1545

To

Peri od: Worksheet 0-4 From 01/01/2016 12/31/2016 Date/Time Prepared:

5/30/2017 11:41 am Hospi ce I SALARI ES OTHER SUBTOTAL (col RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 1.00 2.00 5. 00 3 00 4 00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 PHYSICIAN SERVICES 0 26.00 0 0 0 0 0 0 0 0 0 0 0 0 0 26.00 NURSE PRACTITIONER 22 22 27.00 0 22 27.00 28.00 REGISTERED NURSE 763 0 763 763 28.00 29.00 LPN/LVN 0 29.00 0 4 0 30.00 PHYSI CAL THERAPY 4 4 30.00 OCCUPATIONAL THERAPY 0 0 0 31.00 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDICAL SOCIAL SERVICES 267 267 267 33.00 SPIRITUAL COUNSELING 34.00 0 34.00 0 0 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 37.00 246 246 246 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 0 0 0 0 39.00 IMAGING SERVICES 0 40.00 40.00 0 LABS & DIAGNOSTICS 0 0 0 0 0 41.00 0 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 0 0 42.00 0 42.00 43.00 OUTPATIENT SERVICES 0 43.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 0 44.00 PALLIATIVE CHEMOTHERAPY 45.00 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) C 0 0 0 46.00 100.00 TOTAL 302 1, 302 1, 302 100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		AD HICTMENTS	TOTAL (asl E		
		ADJUSTMENTS	TOTAL (col. 5		
		/ 00	± col. 6)		
	DIRECT PATIENT CARE SERVICE COST CENTERS	6. 00	7. 00		
25. 00	INPATIENT CARE-CONTRACTED		1 0		25 00
					25. 00
26. 00	PHYSI CI AN SERVI CES	0	0		26. 00
27. 00	NURSE PRACTITIONER	0	22	l .	27. 00
28. 00	REGI STERED NURSE	0	763		28. 00
29. 00	LPN/LVN	0	0		29. 00
30. 00	PHYSI CAL THERAPY	0	4		30.00
31. 00	OCCUPATI ONAL THERAPY	0	) 0		31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0		32. 00
33. 00	MEDICAL SOCIAL SERVICES	0	267		33. 00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35. 00
36.00	COUNSELING - OTHER	0	0		36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	246		37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38. 00
39.00	PATIENT TRANSPORTATION	0	0		39. 00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)		ol o		46. 00
	TOTAL *	0	1, 302		100.00
	1			!	

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Health Financial Systems	PARKVIEW WABASH HOS	PITAL, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - DETERMINATION OF HOSPITAL-BASE EXPENSES FOR ALLOCATION	D HOSPICE NET	Provider CO		Peri od: From 01/01/2016	Worksheet 0-5	
		Hospi ce CCN	N: 15-1545	To 12/31/2016	Date/Time Prep 5/30/2017 11:4	oared: 41 am_
				Hospi ce I		
Descriptions			HOSPICE DIREC	T GENERAL	TOTAL EXPENSES	
			EXPENSES (see	e SERVI CE	(sum of cols.	
			instructions	EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
				instructions)		
			1.00	2. 00	3. 00	
GENERAL SERVICE COST CENTERS						

	Descriptions	HUSPICE DIRECT		TOTAL EXPENSES	
		EXPENSES (see		(sum of cols.	
		instructions)		1 + 2)	
			WKST B PART I		
			(see		
			instructions)		
		1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	C	72, 779	72, 779	3. 00
4.00	ADMINISTRATIVE & GENERAL	173, 467	209, 290	382, 757	4.00
5.00	PLANT OPERATION & MAINTENANCE		0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE		0	0	6. 00
7. 00	HOUSEKEEPING		0	0	7. 00
8.00	DI ETARY			0	8.00
9. 00	NURSI NG ADMINI STRATI ON			0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	1, 714	527	2, 241	10.00
11. 00	MEDICAL RECORDS	1, 714	327	2, 241	11. 00
12. 00	STAFF TRANSPORTATION	15, 942		15, 942	12.00
		13, 942		13, 942	
13.00	VOLUNTEER SERVICE COORDINATION PHARMACY	2/ /05		0 27 705	13.00
		36, 605	0	1	•
	PHYSI CI AN ADMINI STRATI VE SERVI CES			0	15. 00
16. 00	OTHER GENERAL SERVICE		0	1	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES		0	0	17. 00
FO 00	LEVEL OF CARE	1 0		1 0	
50.00	HOSPI CE CONTI NUOUS HOME CARE	0	1	0	
	HOSPICE ROUTINE HOME CARE	178, 762		178, 762	1
	HOSPICE INPATIENT RESPITE CARE	759		759	
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 302	!	1, 302	53. 00
(0.00	NONREI MBURSABLE COST CENTERS	1 0			/ 0 00
60.00	BEREAVEMENT PROGRAM	C		0	60.00
61.00	VOLUNTEER PROGRAM			0	61.00
62.00	FUNDRAL SI NG			0	62.00
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS		)	0	63.00
	PALLIATIVE CARE PROGRAM		)	0	64.00
65. 00	OTHER PHYSI CI AN SERVI CES		)	0	65.00
66. 00	RESI DENTI AL CARE		)	0	66.00
67. 00	ADVERTI SI NG		ין	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	)	0	68. 00
	THRI FT STORE	0	)	0	69. 00
	NURSING FACILITY ROOM & BOARD	0	)	0	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	)	0	71. 00
	NEGATI VE COST CENTER	0	)	0	99. 00
100.00	TOTAL	408, 551	282, 596	691, 147	100. 00

 
 PITAL, INC.
 In Lieu of Form CMS-2552-10

 Provi der CCN: 15-1310
 Period: From 01/01/2016 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 5/30/2017 | 11: 41 am
 Heal th FinancialSystemsPARKVIEW WABASCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS

						5/30/201/ 11:4	<u>41 am</u>
					Hospi ce I		
	Descriptions	TOTAL EXPENSES	CAP REL BLDG &	CAP REL MVBLI	EMPLOYEE	SUBTOTAL	
	·		FLX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0		2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	72, 779	0	,	0 72, 779		3. 00
4. 00	ADMINISTRATIVE & GENERAL	382, 757	0		0 17, 376	400, 133	4. 00
5. 00	PLANT OPERATION & MAINTENANCE	002,707	0		0 17, 370	0	5. 00
6. 00	LAUNDRY & LINEN SERVICE		0		0	Ö	6. 00
7. 00	HOUSEKEEPI NG		0		0	0	7. 00
8.00	DI ETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION		0		0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	2, 241	0		0	2, 241	10.00
	MEDICAL RECORDS	2, 241	0		0		
11. 00		15 043	U	1	0	15.043	11.00
12.00	STAFF TRANSPORTATION	15, 942	U	1	0	15, 942	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0 0	Ü	1	0	0	13.00
14.00	PHARMACY	36, 605	Ü		0	36, 605	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	1	0	0	15. 00
16. 00	OTHER GENERAL SERVI CE	0	0	l .	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	1	0	0	17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	178, 762			54, 771	233, 533	51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	759	0	1	0 233	992	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 302	0		0 399	1, 701	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	1	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	1	0 0	0	61. 00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	)	0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	)	0	0	64. 00
65.00	OTHER PHYSICIAN SERVICES	0	O	1	0 0	0	65. 00
66.00	RESI DENTI AL CARE	o	0	)	0 0	0	66. 00
67. 00	ADVERTI SI NG	o	0	,	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	,	0	0	68. 00
69. 00	THRI FT STORE	0	0	1	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD	0	_			0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0		0	0	71. 00
	NEGATIVE COST CENTER		n		o o		99. 00
	TOTAL	691, 147	Ö	1	0 72, 779	691, 147	
	1	37.7117	Č	1	-11	97.7117	1.20.00

	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der C	CN: 15-1310 N: 15-1545	Peri od: From 01/01/2016 To 12/31/2016		epared:
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	Hospi ce I HOUSEKEEPI NG	DI ETARY	
	Descriptions	& GENERAL	OPERATION &	LINEN SERVI		DIETAKT	
		a senerale	MAI NTENANCE	LI MEN GENT	,		
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	400, 133					4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	C				5. 00
6.00	LAUNDRY & LINEN SERVICE	o	C		0		6. 00
7.00	HOUSEKEEPI NG	o	C		0		7. 00
8.00	DI ETARY	o	C		0	C	8.00
9.00	NURSING ADMINISTRATION	o	C		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	3, 081	C		0		10.00
11.00	MEDI CAL RECORDS	o	C		0		11.00
12.00	STAFF TRANSPORTATION	21, 920	C		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	C		0		13.00
14.00	PHARMACY	50, 330	C		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	l ol	C	ol .	0		15. 00
16. 00	OTHER GENERAL SERVICE	o	C		0		16. 00
	PATIENT/RESIDENTIAL CARE SERVICES	o	C		0		17. 00
	LEVEL OF CARE			•		ļ.	
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	321, 099					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 364	C		0 0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2, 339	C		0 0		53.00
	NONREI MBURSABLE COST CENTERS	<u>'</u>		•		•	
60.00	BEREAVEMENT PROGRAM	0	C	)	0		60.00
61.00	VOLUNTEER PROGRAM	o	C		0		61. 00
62.00	FUNDRAI SI NG	o	C		0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	C		0		63.00
64.00	PALLIATIVE CARE PROGRAM	o	C		0		64. 00
65.00	OTHER PHYSICIAN SERVICES	o	C		0		65. 00
66.00	RESI DENTI AL CARE	o	C		0 0		66.00
67.00	ADVERTI SI NG	o	C		0		67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	C		0		68. 00
69. 00	THRI FT STORE	o	C	ol .	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	C		0 0		71.00
	NEGATIVE COST CENTER	o	C		0 0	C	99. 00
100.00	TOTAL	400, 133	C		0 0	c	100.00
	•			•	*		

Provider CON: 15-1310	Heal th	Financial Systems	PARKVIEW WABASH HO	KVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
Hospice CCN: 15-1545   To 12/31/2016   Bate/Time Prepared: 5/30/2017 11:41 am   Hospice   February   Hospice   February   Hospice   February   Hospice   February	COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der Co	CN: 15-1310					
Descriptions						From 01/01/2016	Part I			
Descriptions				Hospi ce CCI	N: 15-1545	To 12/31/2016				
Descriptions						Hospi ca I	3/30/2017 11.4	41 alli_		
ADMINISTRATION   MEDICAL   RECORD   TRANSPORTATION   SERVICE   COORDINATION		Descriptions	NUDSLNG	DOLLTI NE	MEDICAL		VOLUNTEED.			
SUPPLIES		besci i pti ons								
SENERAL SERVICE COST CENTERS			ADMINI STRATION		KECOKDS	TRANSFORTATION				
CENTRAL SERVICE COST CENTERS			9 00		11 00	12 00				
1.00		GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00			
2. 00	1 00							1 00		
3. 00										
4. 00   ADMINISTRATIVE & GENERAL   5. 00   5. 00   FLANT OPERATION & MAINTENANCE   5. 00   6. 00   FLANT OPERATION & MAINTENANCE   6. 00   7. 00   HOUSEKEEPING   7. 00   HOUSEKEEPING   7. 00   HOUSEKEEPING   7. 00   8. 00   HOUSEKEEPING   7. 00   8. 00   FLANY   8. 00   9. 00   NURSI NG ADMINISTRATION   9. 00   9. 00   11.								•		
5. 00   PLANT OPERATION & MAINTENANCE								1		
6. 00		4						•		
7. 00   HOUSEKEEPING								•		
8. 00   DI ETARY		4						1		
9. 00 ROURING ADMINISTRATION ROUTINE MEDICAL SUPPLIES 0 5,322 0 10. 00 ROUTINE MEDICAL SUPPLIES 0 0 5,322 11. 00 REDICAL RECORDS 0 0 0 11. 00 REDICAL RECORDS 0 0 0 0 11. 00 REDICAL RECORDS 0 0 0 0 0 0 0 0 12. 00 REDICAL RECORDS 0 0 0 0 0 0 0 0 0 13. 00 REDICAL RECORDS 0 0 0 0 0 0 0 0 0 13. 00 REDICAL RECORDS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·						1		
10. 00   ROUTINE MEDICAL SUPPLIES   0   5,322   0   11. 00   11.		4						1		
11. 00   MEDICAL RECORDS   0   0   37,862   12. 00   12. 00   13. 00   14		4	-1	E 222				•		
12. 00     37,862     12. 00				5, 322				1		
13. 00   VOLUNTEER SERVICE COORDINATION   0   0   0   0   13. 00     14. 00   PHARMACY   0   0   0   0   14. 00     15. 00   PHYSICIAN ADMINISTRATIVE SERVICES   0   0   0   15. 00     16. 00   OTHER GENERAL SERVICE   0   0   0   16. 00     17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   16. 00     17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   0   0     16. 00   HOSPICE CONTINUOUS HOME CARE   0   0   0   0   0   0   50. 00     17. 00   HOSPICE ROUTINE HOME CARE   0   5, 262   0   37, 431   0   51. 00     18. 00   HOSPICE ROUTINE HOME CARE   0   22   0   159   0   52. 00     19. 00   HOSPICE INPATIENT CARE   0   38   0   272   0   53. 00     19. 00   HOSPICE GENERAL INPATIENT CARE   0   38   0   272   0   53. 00     19. 00   HOSPICE GENERAL INPATIENT CARE   0   38   0   272   0   53. 00     19. 00   HOSPICE GENERAL INPATIENT CARE   0   38   0   272   0   53. 00     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0   0     19. 00   THEN FINSTER   0   0   0   0   0   0     19. 00   THEN FITSTORE   0   0   0   0   0     19. 00   THEN FITSTORE   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0   0   0     19. 00   HOSPICE FORGRAM   0   0   0		4				١ ١		•		
14. 00   PHARMACY		4	0			37, 862		1		
15. 00   PHYSI CI AN ADMINISTRATI VE SERVI CES   0   0   15. 00     16. 00   OTHER GENERAL SERVI CE   0   0   16. 00     17. 00   PATI ENT/RESI DENTI AL CARE SERVI CES   17. 00     18. 00   PATI ENT/RESI DENTI AL CARE SERVI CES   17. 00     19. 00   HOSPI CE CONTI NUOUS HOME CARE   0   0   0   0   0   50. 00     15. 00   HOSPI CE CONTI NUOUS HOME CARE   0   5, 262   0   37, 431   0   51. 00     15. 00   HOSPI CE ROUTI NE HOME CARE   0   5, 262   0   37, 431   0   51. 00     15. 00   HOSPI CE INPATI ENT RESPITE CARE   0   22   0   159   0   52. 00     15. 00   HOSPI CE ROUTI NE HOME CARE   0   38   0   272   0   53. 00     15. 00   HOSPI CE GENERAL INPATI ENT CARE   0   38   0   272   0   53. 00     15. 00   HOSPI CE GENERAL INPATI ENT CARE   0   38   0   272   0   53. 00     15. 00   HOSPI CE GENERAL INPATI ENT CARE   0   38   0   272   0   53. 00     15. 00   HOSPI CE GENERAL INPATI ENT CARE   0   0   0   60. 00     15. 00   HOSPI CE GENERAL INPATI ENT CARE   0   0   0   60. 00     16. 00   VOLUNTEER PROGRAM   0   0   0   61. 00     16. 00   VOLUNTEER PROGRAM   0   0   0   62. 00     16. 00   VOLUNTEER PROGRAM   0   0   0   62. 00     16. 00   O   0   0   0   64. 00     16. 00   O   0   0   65. 00     16. 00   O   0   0   0   65. 00     16. 00   O   0   0   65. 00     16. 00   O   0   0   0   65. 00     17. 00   O   O   0   0   0   0     18. 00   O   0   0   0     18. 00   O   0   0   0     19. 00   NURSI NG FACILITY ROOM & BOARD   0   0   0     17. 00   O   O   O   0   0   0     18. 00   O   O   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0     19. 00   NEGATI VE COST CENTER   0   0   0   0		4	0			0		•		
16. 00 OTHER GENERAL SERVICE 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 17. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 17. 00 18. 00 OFF CARE 18. 00			O			0		1		
17. 00   PATIENT/RESIDENTIAL CARE SERVICES   17. 00   LEVEL OF CARE			O			0	-			
LEVEL OF CARE		· ·	١			0	01	1		
50.00   HOSPI CE CONTI NUOUS HOME CARE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00							17.00		
51.00					ı	ا ما				
Description   Section				-			- 1			
HOSPICE GENERAL INPATIENT CARE   0   38   0   272   0   53.00     NONREIMBURSABLE COST CENTERS		1	-1	•	l .					
NONREI MBURSABLE COST CENTERS   O		1	- I					•		
60. 00       BEREAVEMENT PROGRAM       0       0       60. 00         61. 00       VOLUNTEER PROGRAM       0       0       0       61. 00         62. 00       FUNDRAI SI NG       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE CARE PROGRAM       0       0       0       63. 00         64. 00       PALLI ATI VE CARE PROGRAM       0       0       0       64. 00         65. 00       OTHER PHYSI CI AN SERVI CES       0       0       0       65. 00         66. 00       RESI DENTI AL CARE       0       0       0       66. 00         67. 00       ADVERTI SI NG       0       0       0       67. 00         68. 00       TELEHEALTH/TELEMONI TORI NG       0       0       0       68. 00         69. 00       THRI FT STORE       0       0       0       69. 00         70. 00       NURSI NG FACI LI TY ROOM & BOARD       0       0       0       70. 00         99. 00       NEGATI VE COST CENTER       0       0       0       0       99. 00	53. 00		0	38		0 272	. 0	53.00		
61. 00					ı					
62. 00 FUNDRAI SING 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 65. 00 67. 00 ADVERTI SI NG 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 99. 00			- I			0	-			
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 99. 00			-			0	- 1			
64. 00 PALLIATIVE CARE PROGRAM 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 66. 00 67. 00 ADVERTISING 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 99. 00			-			0	- 1	1		
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 66. 00 67. 00 ADVERTISING 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 99. 00			O			0				
66. 00 RESI DENTI AL CARE 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 0 0 0 0 99. 00			O			0		1		
67. 00   ADVERTISING   0   0   67. 00   68. 00   69. 00   0   68. 00   69. 00   69. 00   69. 00   69. 00   70. 00   NURSING FACILITY ROOM & BOARD   0   0   0   71. 00   0   0   0   0   0   0   0   0   0			0			0				
68. 00   TELEHEALTH/TELEMONI TORI NG   0   0   68. 00   69. 00   THRI FT STORE   0   0   69. 00   70. 00   NURSI NG FACILITY ROOM & BOARD   70. 00   71. 00   OTHER NONREI MBURSABLE (SPECI FY)   0   0   0   71. 00   99. 00   NEGATI VE COST CENTER   0   0   0   99. 00			0			0	-	1		
69. 00		4	0			0		1		
70.00 NURSING FACILITY ROOM & BOARD 70.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 0 99.00		· ·	0			0		1		
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 0 0 0 0 99.00		4	0			0	01	•		
99.00 NEGATIVE COST CENTER 0 0 0 0 0 99.00								1		
		1				0		1		
100 00  TOTAL   0			-1	0		9	-			
100. 00 TOTAL   0  5, 322  0  37, 862  0 100. 00	100.00	TOTAL	0	5, 322	l	0 37, 862	0	100. 00		

Hear th	Financial Systems PF	KKVIEW WABASH	HUSPITAL, INC.		In Lie	eu of form CMS	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der Co	CN: 15-1310	Peri od:	Worksheet 0-6	)
					From 01/01/2016		
			Hospi ce CCI	N: 15-1545	To 12/31/2016		epared:
					11! 1	5/30/2017 11:	41 am
	D	DUADMACY	DUIVCI CL AN	OTHER CENERA	Hospi ce I	TOTAL	
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA		TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
		14.00	SERVI CES	17, 00	CARE SERVICES	10.00	
	CENEDAL CEDALCE COCT CENTEDO	14. 00	15. 00	16.00	17. 00	18. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPING						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY	86, 935					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	00, 700	0				15. 00
16. 00	OTHER GENERAL SERVICE	0	0	Ί	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	U			0		17. 00
17.00	LEVEL OF CARE				0		17.00
EO 00	HOSPICE CONTINUOUS HOME CARE	0	0	,	0	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE	85. 944	0	l .	0	683, 269	1
	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	365	0	1	-		1
52.00			ı .	1	-		1
53. 00	HOSPICE GENERAL INPATIENT CARE	626	0	1	0 0	4, 976	53. 00
	NONREI MBURSABLE COST CENTERS						(0.00
60.00		0			0	0	
61. 00	VOLUNTEER PROGRAM	0			0	0	
62. 00	FUNDRAI SI NG	0			0	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	
64. 00	PALLIATIVE CARE PROGRAM	0			0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	0	0		0	0	66. 00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69.00	THRI FT STORE	0			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					0	70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	ol	0		0 0	0	71.00
99. 00	` ,	o	0	)	0 0	0	1
100.00		86, 935	0	)	0 0	691, 147	
	1	,	_	•	1		

Health Financial Systems	PARKVIEW WABASH HO	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE (	GENERAL SERVICE COSTS	Provider CCN: 15-1310	Peri od:	Worksheet 0-6
STATISTICAL BASIS		Hospi co CCN: 15 1545	From 01/01/2016	Part II

SIAIIS	STICAL BASIS		Hospi ce CCN	N: 15-1545 T	0 12/31/2016	Date/Time Pre 5/30/2017 11:	
					Hospi ce I	0,00,201,111	
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	·	FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
	T	1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS				T		
1.00	CAP REL COSTS-BLDG & FIXT	0	_				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	237, 534			3. 00
4.00	ADMINISTRATIVE & GENERAL	0	0	56, 712	-400, 133	291, 014	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7. 00	HOUSEKEEPING	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSI NG ADMINI STRATI ON	0	0	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	2, 241	•
11. 00	MEDI CAL RECORDS	0	0	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION	0	0	0	0	15, 942	•
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13. 00
14. 00	PHARMACY	0	0	0	0	36, 605	1
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE				1		
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE			178, 762	0	233, 533	1
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0	759	0	992	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	1, 301	0	1, 701	53. 00
	NONREI MBURSABLE COST CENTERS				ı		
60. 00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61. 00
62. 00	FUNDRAI SI NG	0	0	0	0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. 00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66. 00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
69. 00	THRI FT STORE	0	0	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71. 00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Par		0	72, 779		400, 133	1
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 306394	l l	1. 374961	101.00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II Date/Time Prepared: 5/30/2017 11:41 am

STATES	BITCAL BASIS		Hospi ce CC		To 12/31/2016		pared:
					Hospi ce I	37 307 2017 11.	TI dili
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	•	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)	(=======	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		F 00	4 00	7.00	0.00	HRS. )	
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7.00	8. 00	9. 00	
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	0					5. 00
6.00	LAUNDRY & LINEN SERVICE	0	l c				6.00
7.00	HOUSEKEEPI NG	0			O		7. 00
8.00	DI ETARY	0			0 0		8. 00
9.00	NURSING ADMINISTRATION	0			O	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0			O	0	10.00
11. 00	MEDI CAL RECORDS	0			O	0	11. 00
12.00	STAFF TRANSPORTATION	0			O	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0			O	0	13. 00
14. 00	PHARMACY	0			0	0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	•		O	0	
16. 00	OTHER GENERAL SERVICE	0			O	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17. 00
F0 00	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	
51.00	HOSPICE ROUTINE HOME CARE			,		0	1
52. 00 53. 00	HOSPICE INPATIENT RESPITE CARE	0		1	0	1	
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS			'	<u>J</u> 0	0	53.00
60. 00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	0			5	0	
62. 00	FUNDRAI SI NG	0	ł	1	o o	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			Ď	Ö	
64. 00	PALLIATIVE CARE PROGRAM	0			0	l o	
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	
66.00	RESI DENTI AL CARE	0	l o		0	0	66.00
67.00	ADVERTI SI NG	0			O	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			O	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	)	0	0	71. 00
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	)	0 (C		100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	0.000000	0. 000000	101. 00

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CCN: 15-1310		Worksheet 0-6
STATISTICAL BASIS			From 01/01/2016	

STATES	II CAL BASIS		Hospi ce CCI		o 12/31/2016	Date/Time Pre 5/30/2017 11:	pared: 41 am
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL	MEDI CAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVI CE	PHARMACY (CHARGES)	
		SUPPLIES (PATIENT DAYS)	(PATIENT DAYS)	(MI LEAGE)	COORDINATION (HOURS OF		
					SERVICE)		
	[	10.00	11. 00	12. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00 4. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						3. 00 4. 00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMINI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES	5, 003					10.00
11. 00	MEDICAL RECORDS		0				11. 00
12.00	STAFF TRANSPORTATION			18, 538	3		12.00
13.00	VOLUNTEER SERVICE COORDINATION			C	0		13. 00
14.00	PHARMACY			C	0	1, 017, 562	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			( c	0	0	15. 00
16. 00	OTHER GENERAL SERVICE			C	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE	_					
50.00	HOSPI CE CONTI NUOUS HOME CARE	0	0	1	-	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4, 946	0	1		1, 005, 969	•
52. 00 53. 00	HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	21 36	0			4, 271	•
33.00	NONREI MBURSABLE COST CENTERS	30	U	η 133	<u> </u>	7, 322	33.00
60. 00	BEREAVEMENT PROGRAM			1 0	0	0	60.00
61. 00	VOLUNTEER PROGRAM					0	61.00
62. 00	FUNDRAI SI NG		•			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				o	0	63.00
64.00	PALLIATIVE CARE PROGRAM				o	0	64. 00
65.00	OTHER PHYSICIAN SERVICES				o	0	65. 00
66. 00	RESI DENTI AL CARE			C	0	0	66. 00
67.00	ADVERTI SI NG			C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			C	0	0	68. 00
69. 00	THRI FT STORE			C	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			_		_	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			C	이	0	
	NEGATI VE COST CENTER	F 200	_	27.00		0/ 005	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	5, 322	0. 000000	37, 862 2. 042399		86, 935 0. 085435	
101.00	UNIT COST WULTIPLIER	1. 063762	0.00000	y 2. 042399	0.00000	0. 063435	1101.00

Health Financial Systems	PARKVIEW WABASH HOS	PITAL, INC.		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STATISTICAL BASIS	SERVICE COSTS	Provider CCN:	15-1310	Peri od: From 01/01/2016	Worksheet 0-6
STATISTICAL BASIS		Hospi ce CCN:	15-1545		Date/Time Prepared:

			nospi ce coi	N. 15-1545	10 12/31/2010	5/30/2017 11	
-					Hospi ce I	0,00,00,00	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECIFY	CARE SERVICES	3		
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		(171112111 27110)	27.01.07	DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
							1
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9. 00	NURSI NG ADMINI STRATI ON						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY						14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16.00	OTHER GENERAL SERVICE		0				16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	o	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	0		o		52.00
	HOSPICE GENERAL INPATIENT CARE	o	0		0		53.00
	NONREI MBURSABLE COST CENTERS	-1	-		-1		
60.00	BEREAVEMENT PROGRAM		0				60.00
61. 00	VOLUNTEER PROGRAM		0				61. 00
	FUNDRAI SI NG		0				62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63. 00
	PALLIATIVE CARE PROGRAM		0	i .			64. 00
	OTHER PHYSICIAN SERVICES		0				65. 00
	RESI DENTI AL CARE	0	0		0		66. 00
67. 00	ADVERTI SI NG	١	0		O		67. 00
			0				
68. 00	TELEHEALTH/TELEMONI TORI NG		0				68. 00
	THRIFT STORE		0				69.00
	NURSING FACILITY ROOM & BOARD		•				70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		U		71. 00
	NEGATI VE COST CENTER	_	_				99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0		O		100. 00
101. 00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 00000	이		101. 00

Hool +b	Financial Systems PA	ADVVIEW WADACH LI	OSDITAL INC		ln lie	eu of Form CMS-2	DEE2 10
	TIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV		Provider C	CN: 15-1310	Peri od:	Worksheet 0-7	
	OF CARE	TOE COSTS DI			From 01/01/2016		
			Hospi ce CCI	N: 15-1545	To 12/31/2016		
					Hospi ce I	5/30/2017 11:	41 alli_
				Charges by	LOC (from Provi	der Records)	
				9,	, (	,	
	Cost Center Descriptions	From Wkst. C, C		HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		l i ne	1.00	2.00	2.00	4.00	
	ANCHI LADV CEDVI CE COCT CENTEDO	0	1. 00	2.00	3. 00	4. 00	
1. 00	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	66. 00	0. 584992	I	0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67. 00	0. 646304		0	0	
3.00	SPEECH PATHOLOGY	68. 00	0. 000000		0	0	
4. 00	DRUGS CHARGED TO PATIENTS	73. 00	0. 347086		0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0. 347000		0		5.00
6.00	LABORATORY	60.00	0. 172876		0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 319962			0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00	0. 317702				8.00
9. 00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10. 00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11. 00	Totals (sum of lines 1-11)	70.00				•	11.00
11.00	Total's (sam of fiftes f ff)	Charges by LOC		Shared Serv	ice Costs by LOC		11.00
		(from Provider		0.14. 04 00. 1			
		Records)					
	Cost Center Descriptions	HGI P H	CHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGIP (col. 1 x	
	·		col . 2)	col . 3)	col . 4)	col . 5)	
		5. 00	6.00	7.00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0 0	0	
2.00	OCCUPATI ONAL THERAPY	0	0		0	0	
3.00	SPEECH PATHOLOGY	0	0		0	0	0.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0	0	4.00

0

0

0

0

5.00

6. 00

7. 00

8.00

9.00

10.00

0 11.00

5.00

6.00

7. 00

8.00

9.00

DURABLE MEDICAL EQUIP-RENTED

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

RADI OLOGY-THERAPEUTI C

LABORATORY
MEDICAL SUPPLIES CHARGED TO PATIENT
OTHER OUTPATIENT SERVICE COST CENTER

Health Financial Systems	PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE	PER DIEM COST	Provider CCN: 15-1310	Peri od:	Worksheet 0-8

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

| Provider CCN: 15-1310 | Period: From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: 5/30/2017 11: 41 am | Hospice L

					5/30/2017 11:4	41 alli
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	', col . 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0		4. 00
5.00	Program cost (line 3 times line 4)	ŕ		0		5. 00
	HOSPICE ROUTINE HOME CARE			<u>'</u>		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	', col. 7,			683, 269	6. 00
	line 11)				·	
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				4, 946	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				138. 15	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 11)	4, 62	2 65		9. 00
10.00	Program cost (line 8 times line 9)	,	638, 52	8, 980		10.00
	HOSPICE INPATIENT RESPITE CARE		<u> </u>			
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	', col. 8,			2, 902	11. 00
	line 11)				·	
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				21	12. 00
13.00	Total average cost per diem (line 11 divided by line 12)				138. 19	13. 00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 12)	1	7 0		14. 00
15.00	Program cost (line 13 times line 14)		2, 34	9 0		15. 00
	HOSPICE GENERAL INPATIENT CARE			<u> </u>		
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	', col. 9,			4, 976	16. 00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				36	17. 00
18.00	Total average cost per diem (line 16 divided by line 17)				138. 22	18. 00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 13)	3	6 0		19. 00
20.00	Program cost (line 18 times line 19)		4, 97	6 0		20. 00
	TOTAL HOSPICE CARE			<u> </u>		
21.00					691, 147	21. 00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				5, 003	
	Average cost per diem (line 21 divided by line 22)				138. 15	
	1 3 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		'	1		