This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1310 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2024 1:32 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARKVIEW WABASH HOSPITAL, INC. (15-1310) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jean	ne Wickens	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CF0/SVP			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-171, 706	90, 179	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	-130	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		32, 454		0	10.00
10.01	RURAL HEALTH CLINIC II	0		52, 710		0	10. 01
200.00	TOTAL	0	-171, 836	175, 343	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1310 Peri od: Worksheet S-2 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 10 JOHN KISSINGER DR 1.00 PO Box: 1.00 State: IN 2.00 City: WABASH Zip Code: 46992 County: WABASH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 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 Ν 0 3.00 HOSPITAL, INC. Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF PARKVIEW WARASH 157310 99915 N 12/17/2001 N 0 7 00 7.00 HOSPITAL SWING BEDS 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11 00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC RURAL HEALTH CLINIC -158541 99915 06/05/2019 N Ν Ν 15.00 N. MANCHESTER Hospital-Based Health Clinic - RHC RURAL HEALTH CLINIC -158542 99915 Ν 15.01 15.01 07/24/2019 Ν KI SSI NGER Hospital-Based Health Clinic - FQHC 16.00 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) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 22.00 Ν Ν disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 this cost reporting 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 a final UCP to be Ν Ν 22.02 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 in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 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" for yes or "N" for no.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provi der CC	Peri od:	1 /2022	Worksheet S-2 Part I			
				From 01/0° To 12/3°	1/2023	Date/Ti 5/24/20		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	id 0 ys Med	ther li cai d lays	
	1.00	days 2. 00	3. 00	unpai d 4. 00	5. 00	6	. 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in colu 4, Medicaid HMO paid and eligible but unpaid days column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-sta	mn i n	0	0	0		0		24. 00 25. 00
Medicaid eligible unpaid days in column 4, Medicai HMO paid and eligible but unpaid days in column 5.				Urban/Rı	ural S	Date of	Geogr	
26.00 Enter your standard geographic classification (not	waga) status	at the bee	inning of t	1. 0		2. (26. 00
cost reporting period. Enter "1" for urban or "2" 27.00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclass	for rural. wage) status or "2" for r ification in	at the enc ural. If ap column 2.	of the cos	it	2			27. 00
35.00 If this is a sole community hospital (SCH), enter effect in the cost reporting period.	the number of	periods SC	CH status in	1	0			35. 00
				Begi nn 1. 0		Endi 2. (
36.00 Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent d		cript line	36 for numb				-	36. 00
37.00 If this is a Medicare dependent hospital (MDH), en is in effect in the cost reporting period.		r of period	ds MDH statu	ıs	0			37. 00
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates.								38. 00
				1. 0		Y/ 2. (
39.00 Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) 1 "Y" for yes or "N" for no. Does the facility mee accordance with 42 CFR 412.101(b)(2)(i), (ii), or or "N" for no. (see instructions)	(i), (ii), or t the mileage (iii)? Enter	(iii)? Ent requiremer in column 2	er in colum nts in 2 "Y" for ye	nn es		N		39. 00
40.00 Is this hospital subject to the HAC program reduct "N" for no in column 1, for discharges prior to 0c no in column 2, for discharges on or after October	tober 1. Ente	r "Y" for y	es or "N" f/			N		40. 00
					V 1. 00	XVIII 2. 00	XI X 3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital pay	mont for disc	roporti opot	o chara in	accordance	l N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete W Pt. III.	xception for	extraordi na	ary circumst	ances	N	N N	N N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PP 48.00 Is the facility electing full federal capital paym					N N	N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents	in approved (ME programs	? For cost	reporting	N			56. 00
periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decementhe instructions. For column 2, if the response to involved in training residents in approved GME proward are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column	ber 27, 2020, column 1 is grams in the e CRs) MA dir	under 42 ("Y", or if prior year	CFR 413.78(b this hospit or penultim)(2), see al was ate year,				
57.00 For cost reporting periods beginning prior to Dece is this the first cost reporting period during whi at this facility? Enter "Y" for yes or "N" for no residents start training in the first month of thi "N" for no in column 2. If column 2 is "Y", compl complete Wkst. D, Parts III & IV and D-2, Pt. II, beginning on or after December 27, 2020, under 42 which month(s) of the cost report the residents we for yes, enter "Y" for yes in column 1, do not com	mber 27, 2020 ch residents in column 1. s cost report ete Worksheet if applicable CFR 413.77(e re on duty, i plete column imbursement f	in approved If column ing period? E-4. If co E. For cost)(1)(iv) ar f the respo 2, and comp for physicia	d GME progra 1 is "Y", d 2 Enter "Y" blumn 2 is " reporting p nd (v), rega onse to line blete Worksh	ms trained lid for yes or N", periods ardless of 56 is "Y" peet E-4.				57. 00 58. 00
which month(s) of the cost report the residents we for yes, enter "Y" for yes in column 1, do not com	re on duty, i plete column imbursement f	f the respo 2, and comp or physicia	onse to line blete Worksh	e 56 is "Y" neet E-4.				

				Y/N	Line #	Qualification Criterion Code	
	Are you claiming nursing and allied health education			1. 00 N	2.00	3.00	60. (
	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	umn 1. R) NAHE	If column 1				
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61.
20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61.
						1.00	
. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ned			od for which	0.00	62.
. 01	your hospital received HRSA PCRE funding (see Thistruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	see instruction		your hospital	0.00	62.
	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		WABASH HOSP ATA F	ITAL, INC. Provider CC		In Lie Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
				Unwei ghted FTEs Nonprovi der Si te 1.00	FTES in Hospital	5/24/2024 1:3 Ratio (col. 1/ (col. 1 + col. 2))	2 pm
Section 5504 of the ACA Base Year period that begins on or after .				This base yea	r is your cost i	reporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in you	ON Enter in column 1, if line 63 is yes, or your facility trained in the base year period, the number of unweighted non-primary resident FTEs attributable to rotations occurring in all nonpresettings. Enter in column 2 the number of unweighted non-primary resident FTEs that trained in your hospital. Enter in column 3 of (column 1 divided by (column 1 + column 2)). (see instruction Program Name Program Program Name)					0.000000 Ratio (col. 3/	64. 00
	Program Name	Progra	iii code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	(col. 3 + col. 4))	
	1.00	2.	00	3. 00	4.00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.1			65. 00
				Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovid	er Setting	1.00 sEffective	2.00	3.00	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospin (column 1 divided by (column 1 -	ono unweighted non-priman occurring in all nonpo unweighted non-priman tal. Enter in column 3	ry care resi rovider set ry care resi 3 the ratio	i dent ti ngs. i dent	0. (· · · · · · · · · · · · · · · · · · ·		66. 00
	Program Name	Progra	m Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1.00	2.	00	3. 00	4.00	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						3. 000000	37.00

Ν

0.00

Ν

0.00

Ν

0.00

Ν

0 00

94.00

95.00

96.00

97.00

applicable column.

applicable column.

94.00

95.00

96.00

Y" for yes or "N" for no in the applicable column.

Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the

If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

column 2 for title XIX.					
.06 Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed for	Wkst. D.	N	Υ	98.
Pts. I through IV? Enter "Y" for yes or "N" for no in colum					/ 0.
column 2 for title XIX.		, =			
Rural Providers				•	
5.00 Does this hospital qualify as a CAH?			Υ		T105.
6.00 of this facility qualifies as a CAH, has it elected the all	-inclusive meth	nod of payment	N		106.
for outpatient services? (see instructions)		, ,			
7.00 Column 1: If line 105 is Y, is this facility eligible for c	ost reimburseme	ent for I&R	N		107
training programs? Enter "Y" for yes or "N" for no in colum					
Column 2: If column 1 is Y and line 70 or line 75 is Y, do	you train I&Rs	sin an É			
approved medical education program in the CAH's excluded I	PF and/or IRF u	ıni t(s)?			
Enter "Y" for yes or "N" for no in column 2. (see instruct	i ons)	, ,			
7.01 If this facility is a REH (line 3, column 4, is "12"), is i					107
reimbursement for I&R training programs? Enter "Y" for yes	or "N" for no.	(see			
instructions)					
8.00 is this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N		108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2. 00	3.00	4. 00	
9.00 f this hospital qualifies as a CAH or a cost provider, are	N N	N	N	N	109
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1. 00	
0.00 Did this hospital participate in the Rural Community Hospit				N	110
Demonstration) for the current cost reporting period? Enter	"Y" for ves or	"N" for no. If			
complete Worksheet E, Part A, Lines 200 through 218, and Wo		nes 200 through	h 215, as		
		nes 200 throug	h 215, as		
complete Worksheet E, Part A, lines 200 through 218, and Wo		nes 200 throug	h 215, as		
complete Worksheet E, Part A, lines 200 through 218, and Wo		nes 200 throug	h 215, as 1.00	2.00	
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in	the Frontier Co	ommuni ty		2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c	the Frontier Co	ommunity period? Enter	1. 00	2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in	the Frontier Co	ommunity period? Enter	1. 00	2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c	the Frontier Coost reporting polumn 1 is Y, 6	ommunity period? Enter enter the	1. 00	2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c	the Frontier Coost reporting polumn 1 is Y, erticipating in	ommunity period? Enter enter the column 2.	1. 00	2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa	the Frontier Coost reporting polumn 1 is Y, erticipating in	ommunity period? Enter enter the column 2.	1. 00	2.00	111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	the Frontier Coost reporting polumn 1 is Y, erticipating in	ommunity period? Enter enter the column 2. and/or "C"	1. 00 N		111
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	the Frontier Coost reporting polumn 1 is Y, erticipating in dditional beds;	ommunity period? Enter enter the column 2. and/or "C"	1. 00	2.00	
complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural Hea	the Frontier Coost reporting polumn 1 is Y, erticipating in dditional beds;	ommunity period? Enter enter the column 2. and/or "C"	1. 00 N		-
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			5/24/2024 1:	32 pm
	Premi ums	Losses	Insurance	
	1.00		2.00	
18.01 List amounts of malpractice premiums and paid losses:	1. 00	2.00	3.00	0118.01
	3.7, 233			
10.03	46 46	1. 00	2. 00	110.00
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of the properties of		N		118. 02
and amounts contained therein.				
19.00 DO NOT USE THIS LINE				119. 00
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro		N	N	120. 00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for t				
Hold Harmless provision in ACA §3121 and applicable amendments? (see inst	'			
Enter in column 2, "Y" for yes or "N" for no.				
21.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	Υ		121. 00
22.00 Does the cost report contain healthcare related taxes as defined in §1903	3(w)(3) of the	N		122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter				1.22.00
the Worksheet A line number where these taxes are included.				
3.00 Did the facility and/or its subproviders (if applicable) purchase profess		Υ	Y	123. 00
services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column				
for yes or "N" for no.	,			
If column 1 is "Y", were the majority of the expenses, i.e., greater than				
professional services expenses, for services purchased from unrelated org				
located in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no.	r for yes or			
Certified Transplant Center Information				
25.00 Does this facility operate a Medicare-certified transplant center? Enter	"Y" for yes	N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare-certified kidney transplant program, enter the cert	tification data			126. 00
in column 1 and termination date, if applicable, in column 2.	iiiication date			120.00
17.00 If this is a Medicare-certified heart transplant program, enter the certi	fication date			127. 00
in column 1 and termination date, if applicable, in column 2.	6			100.00
28.00 If this is a Medicare-certified liver transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			128. 00
9.00 f this is a Medicare-certified lung transplant program, enter the certif	ication date			129. 00
in column 1 and termination date, if applicable, in column 2.				
30.00 of this is a Medicare-certified pancreas transplant program, enter the ce	erti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 2.81.00 If this is a Medicare-certified intestinal transplant program, enter the	certi fi cation			131. 00
date in column 1 and termination date, if applicable, in column 2.	001 11 11 00 11 011			1.01.00
22.00 If this is a Medicare-certified islet transplant program, enter the certi	fication date			132. 00
in column 1 and termination date, if applicable, in column 2.				122 00
13.00 Removed and reserved 14.00 If this is a hospital-based organ procurement organization (OPO), enter t	the OPO number			133. 00 134. 00
in column 1 and termination date, if applicable, in column 2.	THE OF O HUMBER			101.00
All Providers				
40.00 Are there any related organization or home office costs as defined in CMS		Υ	15H032	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home are claimed, enter in column 2 the home office chain number. (see instruc				
1.00 2.00		3. 00	<u>'</u>	
1.00	ough 143 the name	e and address	of the	
If this facility is part of a chain organization, enter on lines 141 thro			01	141. 00
If this facility is part of a chain organization, enter on lines 141 through the home office and enter the home office contractor name and contractor numbers.	ber.	c Numbor: 000	U I	1141.00
If this facility is part of a chain organization, enter on lines 141 through the home office and enter the home office contractor name and contractor number 1.00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICAL CONTRACTOR'S NAME: WISC	ber.	s Number: 0800		
If this facility is part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers of the part of th	ber.	s Number: 0800		142. 00
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If this facility is part of a chain organization, enter on lines 141 throws home office and enter the home office contractor name and contractor numbers. II. 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSIC SERVICE SERVICE PO Box: 5600	ber. CI ANS Contractor'			
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If this facility is part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers. ON Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSIC SERVICE 12.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 13.00 City: FORT WAYNE State: IN 14.00 Are provider based physicians' costs included in Worksheet A?	cor. CI ANS Contractor' Zi p Code:	468	1. 00 Y	143. 00
If this facility is part of a chain organization, enter on lines 141 thrown home office and enter the home office contractor name and contractor numbers. 1.00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICE SERVICE 2.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 3.00 City: FORT WAYNE State: IN 4.00 Are provider based physicians' costs included in Worksheet A? 5.00 If costs for renal services are claimed on Wkst. A, line 74, are the cost inpatient services only? Enter "Y" for yes or "N" for no in column 1. If	cor. CI ANS Contractor' Zip Code: ts for column 1 is	468	1. 00 Y	143. 00
If this facility is part of a chain organization, enter on lines 141 throws the home office and enter the home office contractor name and contractor numbers. In this facility is part of a chain organization, enter on lines 141 throws the home office and enter the home office contractor name and contractor numbers. Contractor's Name: WISCONSIN PHYSIC SERVICE PO Box: 5600 State: IN It this facility is part of a chain organization, enter on lines 141 throws the home office and enter on lines 141 throws the home office contractor name and contractor numbers.	cor. CI ANS Contractor' Zip Code: ts for column 1 is	468	1. 00 Y	142. 00 143. 00 144. 00 145. 00
If this facility is part of a chain organization, enter on lines 141 throwome office and enter the home office contractor name and contractor numbers. In 1.00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSIC SERVICE 12.00 Street: 10501 CORPORATE DRIVE 13.00 City: FORT WAYNE PO Box: 5600 State: IN 14.00 Are provider based physicians' costs included in Worksheet A? 15.00 If costs for renal services are claimed on Wkst. A, line 74, are the cost inpatient services only? Enter "Y" for yes or "N" for no in column 1. If no, does the dialysis facility include Medicare utilization for this cost	Zip Code: Zip Code: ts for column 1 is t reporting st report?	468	1. 00 Y	143. 00

Health Financial Systems	PARKVI EW WAB	ASH HOS	-		15 .		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Fr		Peri From To	od: 01/01/2023 12/31/2023	Date/Time Pr	epared:
							5/24/2024 1:	32 pm
							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 shillpirin	ed cost irriding methor	ur Elite	Part A	Part B		Title V	Title XIX	149.00
			1. 00	2.00	<u>'</u>	3.00	4.00	
Does this facility contain a provi	der that qualifies fo	r an ex			cati on			
or charges? Enter "Y" for yes or '								
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								158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1.00	\dashv
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	s one o	or more campu	ses in dif	ferent	CBSAs?	N	165. 00
	Name		County		Zip Coc		FTE/Campus	
	0		1. 00	2. 00	3.00	4. 00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. (00 166. 00
							1.00	+
Health Information Technology (HI	() incentive in the Am	eri can	Recovery and	d Reinvestr	nent Ac	t	1.00	
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a mea	ani ngfu	ıl user (line	167 is "Y	'"), ent	ter the		168. 00
reasonable cost incurred for the H	•	,						
168.01 If this provider is a CAH and is r						ardshi p		168. 01
exception under §413.70(a)(6)(ii)′ 169.00 If this provider is a meaningful u	ser (line 167 is "Y")					enter the	0.0	00169.00
transition factor. (see instruction	ons)					Doginaing	Ending	
						Begi nni ng 1. 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR L	ogi ppi pg dato and ond	ina dat	o for the re	porting		1.00	2.00	170. 00
period respectively (mm/dd/yyyy)	egi ilii ilg date and end	ing dat	e for the re	portring				170.00
						1. 00	2. 00	
171.00 fline 167 is "Y", does this prov	vider have any days for	r indiv	i dual s encol	led in		N	2.00	0171.00
section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Enter				171.00

Heal th	Financial Systems PARKVIEW WABASH	HOSPITAL, INC.		In Li€	eu of Form CMS-	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1310	Peri od: From 01/01/2023	Worksheet S-2 Part II	2
				To 12/31/2023	Date/Time Pre	
				Y/N	5/24/2024 1:3 Date	32 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation			_		
1. 00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	corumn 2. (See	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare F		N			2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	ın 3, V FOF				
3.00	Is the provider involved in business transactions, including	ng management	N			3. 00
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		\/ /N	T	D-+-	-
			1. 00	7ype 2. 00	Date 3.00	+
	Financial Data and Reports		1.00	2.00	0.00	
4.00	Column 1: Were the financial statements prepared by a Cert		Y	А	04/18/2024	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	iii abi e iii				
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	+
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provide	r N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		N		7. 00
8.00	Were nursing programs and/or allied health programs approve		ved during th			8. 00
0.00	cost reporting period? If yes, see instructions.					0.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	•	cai education	N		9. 00
10.00	Was an approved Intern and Resident GME program initiated of		he current	N		10.00
44 00	cost reporting period? If yes, see instructions.					44.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R In an App	proved	N		11. 00
	reaching magnam on worksheet A: The yes, see mistractions.				Y/N	
	E				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	-i one		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	13. 00
	period? If yes, submit copy.					
14. 00		nce amounts wa	nived? If yes	, see	N	14. 00
	instructions. Bed Complement					
15. 00	Did total beds available change from the prior cost reporti			tructions.	Υ	15. 00
			t A		rt B	
		Y/N 1. 00	2. 00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	1 0.00	1.00	
16.00	Was the cost report prepared using the PS&R Report only?	Y	03/31/2024	Y	03/31/2024	16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	leither column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.		1			1

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 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/24/2024 1:3	epared:
		Descr	i pti on	Y/N	Y/N	
20.00	LE Line 1/ on 17 in the most of the DCOD		0	1.00	3. 00 N	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN	20. 00
	,	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere lf yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	·	0 .		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	<pre>Interest Expense Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.</pre>	ntered into dur	ing the cost	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service R	eserve Fund)	N	29. 00
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	, see	N	30. 00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	N	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		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 no, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans			,		
34. 00	Were services furnished at the provider facility under an a lf yes, see instructions.	nrrangement wit	th provider-b	ased physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office?			37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38. 00
39. 00	j ' '			, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	instructions.					
		1.	00			
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	SHANNON		ECENBARGER		41.00
42. 00	respectively. Enter the employer/company name of the cost report preparer.	PARKVIEW HEALT	TH SYSTEM, INC	C.		42. 00
43. 00		N/A		SHANNON. ECENBAI	RGER@PARKVI EW.	43. 00

Heal th	Financial Systems PARKVIEW WAB	HOSPITAL, INC.			In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der C	CN: 15-1310	Peri		Worksheet S-2	2
					To	n 01/01/2023 12/31/2023	Part II Date/Time Pre 5/24/2024 1:3	
			3.	00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position		REIMBURSEMENT	DI RECTOR				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 cos	t						43.00
	report preparer in columns 1 and 2, respectively.							

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 PARKVIEW V

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

				7	To 12/31/2023	Date/Time Prep 5/24/2024 1:32	
						I/P Days / 0/P	z piii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA			•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	18	6, 570	79, 728. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO I RF Subprovi der					_	4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospi tal Adul ts & Peds. Swing Bed NF			,,	70 700 00	0	6. 00
7. 00	Total Adults and Peds. (exclude observation		18	6, 570	79, 728. 00	0	7. 00
8. 00	beds) (see instructions)						8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				o	13. 00
14. 00	Total (see instructions)	10.00	18	6, 570	79, 728. 00	0	14. 00
15. 00	CAH visits				,	o	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVIDER - IPF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC	88. 00				o	25. 00 26. 00
26. 00	RURAL HEALTH CLINIC	88. 01				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	18			U	27. 00
28. 00	Observation Bed Days		10			o	28. 00
29. 00	Ambul ance Tri ps					Ü	29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0				32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	(0	0	34. 00

Provider CCN: 15-1310

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 1: 32 pm

		I/P Days	o/P Visits	/ Trips		Equi val ents	Z piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7100	0.00	7. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 120	79	3, 322			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)	814	266				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	56	0	107			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 176	79	3, 429			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	1, 176	79	3, 429	0. 00	153. 55	14. 00
15. 00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits	0	0	0			15. 10
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00 24. 00
24. 00 24. 10	HOSPICE			121			24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC			121			25. 00
26. 00	RURAL HEALTH CLINIC	2, 058	49	12, 507	0. 00	15. 14	
26. 00	RURAL HEALTH CLINIC II	4, 451	591	44, 697	0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	4,431	0	44, 097	0.00		26. 25
27. 00	Total (sum of lines 14-26)		O	0	0.00		27. 00
28. 00	Observation Bed Days		44	1, 517	0.00	177. 73	28. 00
29. 00	Ambulance Trips	0	77	1, 317			29. 00
30. 00	Employee discount days (see instruction)			10			30.00
31. 00	Employee discount days (see l'istraction)			10			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room			0			32. 00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	o	0	0			34. 00
	1 1 3 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-1	-1		l		

Provider CCN: 15-1310

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/24/2024	1:32 pm

						5/24/2024 1: 3	2 pm
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	II LIE V	I II LI C AVIII	II LI E XIX	Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA	11100	12.00	10.00	11100	101 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(415	25	1, 220	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)			252	99		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	415	25	1, 220	14. 00
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	4						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	4						19.00
20.00	NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. 00 24. 00
24. 00							24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 00	RURAL HEALTH CLINIC II	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see First detroit)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
02.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

	<u> </u>	ARKVIEW WABASH				eu of Form C		2552-1
HOSPI T	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1310	Peri od: From 01/01/202	Worksheet	S-8	
			Component	CCN: 15-8541	To 12/31/202	3 Date/Time		
					RHC I	5/24/2024	1: 32	2 pm
					THIS I			
					1	1.00		
1 00	Clinic Address and Identification				1104 N. WAYAIF	CT		1
1. 00	Street		Ci	ty	1104 N. WAYNE State	ZIP Code		1. (
				00	2. 00	3.00		
2. 00	City, State, ZIP Code, County		NORTH MANCHEST			N 46962		2. (
2 00	LIOCOLTAL DACED FOLICO ONLY: Decimation Fat	on "D" for runs	.l on "II" fon i	mh an		1.00	0	2 /
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	ii or u ror t		nt Award	Date	U	3. (
					1. 00	2.00		
	Source of Federal Funds							
1. 00	Community Health Center (Section 330(d), PHS							4. (
5. 00	Migrant Health Center (Section 329(d), PHS A							5.
5. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS ACT)						6. 7.
3. 00	Look-Alikes							8.
9. 00	OTHER (SPECIFY)							9.
0.00	Does this facility operate as other than a h	ospital based [DUC or FOUC2 En	tor "V" for	1. 00 N	2.00	0	10.
0. 00	yes or "N" for no in column 1. If yes, indic				ĮN.		٥	10.
	2. (Enter in subscripts of line 11 the type o hours.)							
		Sur	day	N	londay	Tuesday		
		from	to	from	to	from		
	Eacility hours of operations (1)	1.00	2. 00	3. 00	4. 00	5. 00		
1. 00	Facility hours of operations (1)	1.00	2.00					11.
1. 00	Facility hours of operations (1)	1.00	2.00	3. 00	4. 00	5. 00		11.
	CLINIC			08: 00	17: 00			
12. 00	CLINIC Have you received an approval for an exception	on to the produ	uctivity standa	08: 00 rd?	17: 00 1. 00 N	08: 00		12. (
2. 00	Have you received an approval for an exception is this a consolidated cost report as define	on to the produ	uctivity standa	08: 00 rd? 9, section	17: 00	08: 00	0	12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the produ d in CMS Pub. 1	uctivity standa 00-04, chapter enter in colum	08:00 rd? 9, section in 2 the	17: 00 1. 00 N	08: 00	0	12.
12. 00	Have you received an approval for an excepting the state of the state	on to the produ d in CMS Pub. umn 1. If yes, List the names	uctivity standa 00-04, chapter enter in colum s of all provic	o8:00 rd? 9, section n 2 the ers and	17: 00 1. 00 N	08: 00		12. (
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the produ d in CMS Pub. 7 umn 1. If yes, List the names	uctivity standa 00-04, chapter enter in colum s of all provic	nd? 9, section 1 2 the ers and 2 (as define	17: 00 1. 00 N	08: 00		12. (13. (
12. 00 13. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	on to the product on to the product of the product of the names ing multiple controlly.	uctivity standa 00-04, chapter enter in colum s of all provic onsolidated RHC for yes or "N"	p8:00 rd? 9, section n 2 the ers and s (as define for no. If	17: 00 1. 00 N	08: 00		12. (13. (
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the product of the control of	uctivity standa 00-04, chapter enter in colum s of all provic onsolidated RHC For yes or "N" bings and compl	nd? 9, section 1 2 the 1 ers and 2 s (as define 2 for no. If 1 ete a	17: 00 1. 00 N N	08: 00		12. (13. (
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2. 00 3. 00	Have you received an approval for an excepting this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" oings and compl Consolidated cs in the group	rd? 9, section 1 2 the ers and s (as define for no. If ete a RHC grouping ing or	17: 00 1. 00 N N	08: 00		12. (13. (
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2. 00 3. 00 3. 01	Have you received an approval for an exception of this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH.	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC for yes or "N" oings and compl Consolidated cs in the group	nd? 9, section 1 2 the 1 ers and 2 (as define 2 for no. If 3 ete a 4 RHC grouping 3 ing or Prov	17: 00 1. 00 N N	08: 00		12. (13. (
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12. 00 13. 00 13. 01	Have you received an approval for an excepting this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. In this selow. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH. RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC For yes or "N" bings and compl Consolidated consolidated consolidated consolidated	nd? 9, section 1 2 the 1 ers and 1 s (as define 1 for no. If 1 ete a 1 RHC grouping 1 ing or 1 Prov 1 XVIII	17:00 1.00 N N IS ider name 1.00	08: 00 2. 00 CCN 2. 00	0	12. 13. 13.
12. 00 13. 00 13. 01	Have you received an approval for an exception list this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. In this report. In the second of this report. In the second of this report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH. RHC/FQHC name, CCN	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC For yes or "N" bings and compl Consolidated consolidated consolidated consolidated	nd? 9, section 1 2 the 1 ers and 1 s (as define 1 for no. If 1 ete a 1 RHC grouping 1 ing or 1 Prov 1 XVIII	17:00 1.00 N N IS ider name 1.00	08: 00 2. 00 CCN 2. 00	0	12. 13. 1
12. 00 13. 00 13. 01	Have you received an approval for an excepting this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FOHC name, CCN RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC For yes or "N" bings and compl Consolidated consolidated consolidated consolidated	nd? 9, section 1 2 the 1 ers and 1 s (as define 1 for no. If 1 ete a 1 RHC grouping 1 ing or 1 Prov 1 XVIII	17:00 1.00 N N IS ider name 1.00	08: 00 2. 00 CCN 2. 00	0	12. 13. 13.
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12. 00 13. 00 13. 01	Have you received an approval for an excepting this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FOHC name, CCN RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the product of	uctivity standa 00-04, chapter enter in colum s of all provice consolidated RHC For yes or "N" bings and compl Consolidated consolidated consolidated consolidated	nd? 9, section 1 2 the 1 ers and 1 s (as define 1 for no. If 1 ete a 1 RHC grouping 1 ing or 1 Prov 1 XVIII	17:00 1.00 N N IS ider name 1.00	08: 00 2. 00 CCN 2. 00	0	11. (1. (1. (1. (1. (1. (1. (1. (1. (1.

Health Financial Systems F	PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CM					2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	Provider CCN: 15-1310 Pe		Worksheet S-8	3
		Component	CCN: 15-8541	From 01/01/2023 To 12/31/2023		epared: 32 pm
				RHC I		
		Cou	ınty			
	_	4.	00			
2.00 City, State, ZIP Code, County		WABASH				2. 00
	Tuesday	Wedn	Wednesday		sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 00	17: 00				11. 00

	<u> </u>	ARKVIEW WABASH	HOSPITAL, INC.	ON 45 1010		ieu of Form C		552-1
HOSPI 7	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1310	Period: From 01/01/202	Worksheet	S-8	
			Component	CCN: 15-8542	To 12/31/202	23 Date/Time		
					RHC II	5/24/2024	1: 32	2 pm
					I KIIO I I			
						1.00		
00	Clinic Address and Identification				O TOTAL KI CCLA	ICED DD		1 (
1.00	Street		Ci	ty	8 JOHN KISSIN State	ZIP Code	,	1. (
				00	2. 00	3. 00	,	
2. 00	City, State, ZIP Code, County		WABASH			N 46992		2. (
2 00	HOCDITAL BACED FOLICE ONLY. Decimpetion For	on "D" for runs	.l on "II" fon i	mh an		1.00	0	2 (
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	ar or u ror c		nt Award	Date	U	3. (
					1. 00	2.00		
	Source of Federal Funds							
1.00	Community Health Center (Section 330(d), PHS							4. (
. 00	Migrant Health Center (Section 329(d), PHS A							5. (
. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	o(u), PHS ACT)					ŀ	6. 7.
3. 00	Look-Alikes							8.
. 00	OTHER (SPECIFY)							9.
					1.00			
0 00	Does this facility operate as other than a h	osnital based [DUC or EOUC2 En	tor "V" for	1. 00 N	2.00	0	10.
0. 00	yes or "N" for no in column 1. If yes, indic				IN		۷	10.
	2. (Enter in subscripts of line 11 the type o hours.)							
		Sur	day	N	londay	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)	1. 00	2.00	3. 00	4. 00	5. 00		
1.00	TCLINIC			08: 00	17: 00	08: 00		11. (
1. 00	CLINIC			08: 00	17: 00	08: 00		11. (
					1.00	08: 00		
2. 00	Have you received an approval for an exception			rd?	1. 00 N			12. (
2. 00	Have you received an approval for an exception is this a consolidated cost report as define	d in CMS Pub. 1	100-04, chapter	rd? 9, section	1.00		0	12. (
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2. 00 3. 00	Have you received an approval for an exception is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the names	100-04, chapter enter in colum s of all provic	rd? 9, section in 2 the ers and	1. 00 N N			12. (13. (
2. 00 3. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	d in CMS Pub. umn 1. If yes, List the names ing multiple co	100-04, chapter enter in colum s of all provic onsolidated RHC	rd? 9, section n 2 the ers and s (as define	1. 00 N N			12. (13. (
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2. 00 3. 00	Have you received an approval for an excepting this aconsolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. Numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	100-04, chapter enter in colums of all providence on solidated RHC for yes or "N" bings and compliconsolidated cs in the group	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	1.00 N N	2.00		12. (13. (13. (
2. 00 3. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered compared to the second consolidated are comprised exclusively of grandfathered compared to the second consolidated are comprised exclusively of grandfathered consolidated exclusively of grandfathered exclusively exclusively exclusively exclusively exclusively exclusively exclusively exclusively excl	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	100-04, chapter enter in colums of all providence on solidated RHC for yes or "N" bings and compliconsolidated cs in the group	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	1.00 N N d N	2. 00		12. (13. (
2. 00 3. 00 3. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered compared to the second consolidated are comprised exclusively of grandfathered compared to the second consolidated are comprised exclusively of grandfathered consolidated exclusively of grandfathered exclusively exclusively exclusively exclusively exclusively exclusively exclusively exclusively excl	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC	100-04, chapter enter in colums of all providence on solidated RHC for yes or "N" bings and compliconsolidated cs in the group	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	1.00 N N	2.00		12. (13. (
2. 00 3. 00 3. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH.	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. (13. (
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exception of the state of the sta	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group	100-04, chapter enter in colums of all providence on solidated RHC for yes or "N" bings and compl Consolidated cs in the group bing.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. (
12. 00 13. 00 13. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH. RHC/FOHC name, CCN	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. (
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. 13. 13. 14. 1
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colnumber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. 13.
12. 00 13. 00 13. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. 13. 13. 14. 1
12. 00 13. 00 13. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. (
12. 00 13. 00 13. 01	Have you received an approval for an exceptils this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colums of all providence on solidated RHCFor yes or "N" bings and complicated cas in the grouping.	rd? 9, section n 2 the ers and s (as define for no. If ete a RHC grouping ing or Prov	1.00 N N S ider name 1.00	2. 00 CCN 2. 00	0	12. (13. (

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form					2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	Provider CCN: 15-1310 Pe		Worksheet S-8	3
		Component	CCN: 15-8542	From 01/01/2023 To 12/31/2023	Date/Time Pro 5/24/2024 1:3	epared: 32 pm
				RHC II		
		Cou	unty			
		4.	.00			
2.00 City, State, ZIP Code, County		WABASH				2. 00
	Tuesday	Wedn	Wednesday		sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	Financial Systems PARKVIEW WABASH HOSPITAL, II	NC.	In Lie	eu of Form CMS-2	2552-10	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1310	Period: From 01/01/2023 To 12/31/2023		pared:	
				1. 00		
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1	
1.00	Cost to charge ratio (see instructions)			0. 255092	1.00	
	Medicaid (see instructions for each line)			0.200072		
2.00	Net revenue from Medicaid			1, 468, 022	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paym	ents from Medic	ai d?		4. 00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medi			0	5. 00	
6. 00	Medicaid charges			15, 480, 029		
7. 00	Medicaid cost (line 1 times line 6)			3, 948, 832		
8. 00	Difference between net revenue and costs for Medicaid program (see ins	2, 480, 810				
	Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP	147, 668	9.00			
10.00	Stand-alone CHIP charges	879, 513	10.00			
11.00	Stand-alone CHIP cost (line 1 times line 10)	224, 357	11. 00			
12.00	Difference between net revenue and costs for stand-alone CHIP (see ins	tructions)		76, 689	12. 00	
	Other state or local government indigent care program (see instruction)		1	
13.00	Net revenue from state or local indigent care program (Not included on	lines 2, 5 or	9)	3, 055, 545	13. 00	
14. 00	Charges for patients covered under state or local indigent care progra 10)	m (Not included	in lines 6 or	24, 661, 611	14. 00	
15.00	State or local indigent care program cost (line 1 times line 14)			6, 290, 980	15. 00	
16. 00	Difference between net revenue and costs for state or local indigent c			3, 235, 435	16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and s	tate/local indi	gent care progra	ns (see		
17 00	instructions for each line)	L 1 &			17 00	
	Private grants, donations, or endowment income restricted to funding c			0		
18.00	Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indige		o (our of lines	0		
19. 00	8, 12 and 16)	nt care program	s (sull of fines	5, 792, 934	19.00	
		Uni nsured	Insured	Total (col. 1		
		patients	pati ents	+ col . 2)		
		1.00	2.00	3.00		
	Uncompensated care cost (see instructions for each line)			5.55		
20.00	Charity care charges and uninsured discounts (see instructions)	2, 040, 0	75 1, 223, 623	3, 263, 698	20. 00	
21. 00	Cost of patients approved for charity care and uninsured discounts (se instructions)	e 520, 4	07 1, 101, 645	1, 622, 052	21. 00	
22. 00	100 Payments received from patients for amounts previously written off as 0 0 0 charity care					
23. 00	Cost of charity care (see instructions)	520, 4	07 1, 101, 645	1, 622, 052	23. 00	

Heal th	Financial Systems	PARKVIEW WABASH HOS	PITAI INC		In Lie	eu of Form CMS-	- 2552 - 10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	N: 15-1310	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-7 Parts I & II	10 epared:
						1. 00	
	PART II - HOSPITAL DATA						
	Uncompensated and Indigent Care Cost-to-C	harge Ratio					
1.00	Cost to charge ratio (see instructions)						1. 00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid						2. 00
3. 00	Did you receive DSH or supplemental payme						3. 00
4.00	If line 3 is yes, does line 2 include all				aı d'?		4. 00
5.00	If line 4 is no, then enter DSH and/or su	ipplemental payments f	rom Medicaio	d			5.00
6.00	Medicaid charges						6.00
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions)						7. 00 8. 00
6.00	Children's Health Insurance Program (CHIP						8.00
9. 00	Net revenue from stand-alone CHIP) (see mistructions r	or each fine	<i>-</i>)			9.00
							10.00
	0 Stand-alone CHIP cost (line 1 times line 10)					11.00	
	Difference between net revenue and costs		(see instru	ctions)			12. 00
	Other state or local government indigent	care program (see ins	tructions fo	or each line)	•	
13.00	Net revenue from state or local indigent	care program (Not inc	luded on lir	nes 2, 5 or	9)		13. 00
14. 00	Charges for patients covered under state 10)	or local indigent car	e program (1	Not included	lin lines 6 or		14. 00
15.00	State or local indigent care program cost	(line 1 times line 1	4)				15. 00
16. 00	Difference between net revenue and costs						16. 00
	Grants, donations and total unreimbursed instructions for each line)				gent care progra	ms (see	
	Private grants, donations, or endowment i						17. 00
	Government grants, appropriations or tran						18.00
19. 00	Total unreimbursed cost for Medicaid , CH 8, 12 and 16)	IP and state and loca	I indigent o	care program	ns (sum of lines		19. 00
				Uni nsured		Total (col. 1	
				pati ents	pati ents	+ col . 2)	
		£		1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions		, 1				1 20 00
	Charity care charges and uninsured discou Cost of patients approved for charity car						20.00
∠1.00	instructions)	e and unimsured disco	uiits (see				21.00
22. 00	Payments received from patients for amoun	ts previously written	off as				22. 00
00	charity care						
23 00	Cost of charity care (see instructions)				1		23 00

17. 00	7.00 Private grants, donations, or endowment income restricted to funding charity care				
18. 00	Government grants, appropriations or transfers for support of hospital op			18. 00	
19. 00		(sum of lines		19. 00	
. ,	8, 12 and 16)	oar o programo	(04 01 111100		. ,
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)	•			
20.00	Charity care charges and uninsured discounts (see instructions)				20. 00
21.00	Cost of patients approved for charity care and uninsured discounts (see				21.00
	instructions)				
22.00	Payments received from patients for amounts previously written off as				22. 00
	charity care				
23.00	Cost of charity care (see instructions)				23. 00
				1.00	
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a Length of	stay limit		24. 00
	imposed on patients covered by Medicaid or other indigent care program?				
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	s length of		25.00
	stay limit				
25. 01	Charges for insured patients' liability (see instructions)				25. 01
26.00	Bad debt amount (see instructions)				26.00
27.00	Medicare reimbursable bad debts (see instructions)				27. 00
27. 01	Medicare allowable bad debts (see instructions)				27. 01
28.00	Non-Medicare bad debt amount (see instructions)				28. 00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	instructions)			29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31.00

	ARKVIEW WABASH HO				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO		eri od:	Worksheet A	
			T	rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
					5/24/2024 1:3	
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Tri al Balance	
					(col. 3 +-	
	1. 00	2. 00	3.00	4. 00	<u>col. 4)</u> 5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT		3, 394, 770	3, 394, 770	-987, 705	2, 407, 065	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		28, 112			1, 092, 180	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 927, 313	4, 567, 204			6, 494, 517	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	837, 027	19, 237, 294		-76, 363	19, 997, 958	5. 00
7. 00 00700 OPERATI ON OF PLANT	319, 929	780, 277			1, 100, 206	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	017,727	114, 928			220, 785	8.00
9. 00 00900 HOUSEKEEPI NG	323, 538	135, 007			352, 688	9. 00
10. 00 01000 DI ETARY	551, 549	347, 736			114, 603	10.00
11. 00 01100 CAFETERI A	0	0.77700	0,7,7,200		771, 342	11.00
13. 00 01300 NURSING ADMINISTRATION	525, 187	7, 588			532, 775	13. 00
15. 00 01500 PHARMACY	778, 869	105, 481	884, 350		884, 350	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0			0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				·		
30. 00 03000 ADULTS & PEDIATRICS	1, 907, 834	788, 612	2, 696, 446	0	2, 696, 446	30. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	988, 132	758, 635	1, 746, 767	0	1, 746, 767	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 304, 257	792, 628			2, 096, 885	54.00
60. 00 06000 LABORATORY	0	2, 513, 296			2, 513, 296	60.00
66. 00 06600 PHYSI CAL THERAPY	1, 311, 220	37, 550			1, 104, 161	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0		172, 398	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	72, 211	72, 211	68. 00
69. 00 06900 ELECTROCARDI OLOGY	793, 301	120, 322			913, 623	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 187, 306			197, 754	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	., ,	1, 989, 552	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	5, 457, 815	5, 457, 815	0	5, 457, 815	73. 00
OUTPATIENT SERVICE COST CENTERS	400 470				0 (77 (4)	
88. 00 08800 RURAL HEALTH CLINIC	193, 173	2, 484, 443			2, 677, 616	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	702, 295	5, 499, 884			6, 202, 179	88. 01
90. 00 09000 CLI NI C	95, 644	33, 200			142, 184	90.00
90. 01 09001 SENI OR CARE	491, 117	47, 549			538, 666	90. 01
91. 00 09100 EMERGENCY	1, 205, 588	693, 118	1, 898, 706	0	1, 898, 706	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	1, 050	-219, 948	-218, 898	0	-218, 898	95. 00
SPECIAL PURPOSE COST CENTERS	1,030	-217, 740	-210, 070	<u> </u>	-210, 070	75.00
113. 00 11300 NTEREST EXPENSE		0	0	0	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 257, 023	49, 912, 807			64, 169, 830	
NONREI MBURSABLE COST CENTERS	.,,==,,,==,	,,		-1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 766	5, 766	0	5, 766	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	80, 316	394, 300			474, 616	192. 00
192. 01 19201 PV WABASH HEALTH CLINC-CASS	0	0	0	o		192. 01
192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	o		192. 02
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	o		192. 03
194. 00 07950 FITNESS CENTER	o	0	0	n		194. 00
194. 01 07951 FOUNDATI ON	0	0	0	o		194. 01
194. 02 07952 NEW DIRECTION	ol	0	l o	l ol		194. 02
194. 03 07953 COMMUNITY & VOLUNTEER SERVICES	ol	34, 023	34, 023	l ol		194. 03
194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS	ol	0	0	l ol	0	194. 04
194. 05 07955 OCCUPATI ONAL HEALTH	o	0	Ō	o		194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 337, 339	50, 346, 896	64, 684, 235	o	64, 684, 235	
	•			·		

Provider CCN: 15-1310

| Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/24/2024 1:32 pm

				5/24/2024 1: 3	2 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	561, 116	2, 968, 181		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 946	1, 094, 126		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-17, 758	6, 476, 759		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 709, 273	17, 288, 685		5. 00
7.00	00700 OPERATION OF PLANT	-435	1, 099, 771		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	220, 785		8. 00
9.00	00900 HOUSEKEEPI NG	0	352, 688		9. 00
10.00	01000 DI ETARY	-1, 310	113, 293		10.00
11. 00	01100 CAFETERI A	-246, 353	524, 989		11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	532, 775		13. 00
15. 00	01500 PHARMACY	-90, 168	794, 182		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	7 74, 102		16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	U U		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	-422, 751	2, 273, 695		30. 00
43. 00	04300 NURSERY	0	2, 273, 073		43. 00
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		10.00
50. 00	05000 OPERATI NG ROOM	-1, 500	1, 745, 267		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	l control of the cont	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-10, 999	2, 085, 886		54.00
60.00	06000 LABORATORY	-10, 777	2, 513, 296	l control of the cont	60.00
66. 00	06600 PHYSI CAL THERAPY	0	1, 104, 161		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 104, 101		67.00
68. 00	06800 SPEECH PATHOLOGY	0	72, 211		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	913, 623		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
71. 00 72. 00	07200 I MPL. DEV. CHARGED TO PATTENTS	0	197, 754 1, 989, 552		71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	-98			73.00
73.00	OUTPATIENT SERVICE COST CENTERS	-90	5, 457, 717		73.00
88. 00	08800 RURAL HEALTH CLINIC	-1, 058	2, 676, 558		88. 00
88. 01	08801 RURAL HEALTH CLINIC	-3, 304			88. 01
90.00	09000 CLINIC	-3, 304	6, 198, 875		90.00
		_	142, 184		
90. 01	09001 SENI OR CARE	-31, 625	507, 041		90. 01
91. 00	09100 EMERGENCY	0	1, 898, 706		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
05.00	OTHER REIMBURSABLE COST CENTERS	210, 000	0		05 00
95. 00	09500 AMBULANCE SERVICES	218, 898	0		95. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	0	0		113. 00
118.00		-2, 754, 672		l .	118. 00
116.00	NONREI MBURSABLE COST CENTERS	-2, 734, 672	61, 415, 158		1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 766		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	474, 616	l control of the cont	192.00
	19201 PV WABASH HEALTH CLINC-CASS	0	474, 010	·	192. 00
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0		192. 02
	19203 PV WABASH HEALTH CLINC-N. WANCH	0	0		192. 02
	007950 FITNESS CENTER	0	0		194. 00
	107950 FITNESS CENTER	0	0	l .	194. 00
	107951 FOUNDATION 207952 NEW DIRECTION	0	0		194. 01
					194. 02
	3 O7953 COMMUNITY & VOLUNTEER SERVICES	0	34, 023		
	07956 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 04
	507955 OCCUPATIONAL HEALTH	0 754 (72	(1 000 5(0		194. 05
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 754, 672	61, 929, 563		200. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-1310	Peri od:	Worksheet A-6

RECLAS	STELCATIONS			Provider	CN: 15-1310	From 01/01/2023	worksneet P	
						To 12/31/2023	Date/Time F 5/24/2024 1	
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	A - Rehab Therapy							
1.00	OCCUPATI ONAL THERAPY	67.00	167, 598	4, 800				1. 00
2.00	SPEECH PATHOLOGY	68. 00	70, 201	2, 010				2. 00
	TOTALS		237, 799	6, 810				
	B - Clinic Dietician	<u> </u>	· · ·					
1.00	CLINIC	90.00	13, 340					1.00
			13, 340					
	C - Cafeteria	<u> </u>	· · ·					
1.00	CAFETERI A	11. 00	468, 588	302, 754				1. 00
			468, 588	302, 754				
	E - Depreciation		,					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00		1, 030, 890				1.00
				1, 030, 890				
	F - Implantable Devices		-1	, ,				
1.00	IMPL. DEV. CHARGED TO	72. 00		1, 989, 552				1.00
	PATI ENTS			,				
				1, 989, 552				
	G - Insurance	<u> </u>	<u> </u>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		43, 185				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00		33, 178				2. 00
				76, 363				
	H - Laundry	<u> </u>	<u> </u>					
1.00	LAUNDRY & LINEN SERVICE	8. 00		105, 857				1.00
				105, 857				
	I - N. Manchester RHC Salary			·				
1.00	RURAL HEALTH CLINIC	88. 00	1, 310, 189					1.00
			1, 310, 189					
	J - Kissinger RHC Salary							
1.00	RURAL HEALTH CLINIC II	88. 01	2, 717, 893					1.00
			2, 717, 893					
500.00	Grand Total: Increases		4, 747, 809	3, 512, 226				500. 00
	1	'	., . ,					1

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

Provider CCN: 15-1310

						10 12/31/2023	5/24/2024 1:32 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - Rehab Therapy						
1.00	PHYSI CAL THERAPY	66. 00	237, 799	6, 810	0		1.00
2.00		000	0	0	<u> </u>		2. 00
	TOTALS		237, 799	6, 810)		
	B - Clinic Dietician						
1.00	DI ETARY	1000	13, 340				1.00
			13, 340	0)		
	C - Cafeteria						
1.00	DI ETARY	<u>10.</u> 00	<u>468, 5</u> 88	30 <u>2, 7</u> 54			1. 00
			468, 588	302, 754			
	E - Depreciation					T	
1.00	CAP REL COSTS-BLDG & FIXT	1.00		<u>1, 030, 8</u> 90			1. 00
			0	1, 030, 890)		
	F - Implantable Devices					T	
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00		1, 989, 552	2		1.00
	PATI ENT	+				1	
			0	1, 989, 552	!		
4 00	G - Insurance	F 00		7/ 0/0	10		1.00
1.00	ADMINISTRATIVE & GENERAL	5. 00		76, 363	12 12		1.00
2.00		+				<u> </u> 	2. 00
	II Lounder		U	76, 363	5		
1.00	H - Laundry HOUSEKEEPING	9.00		105, 857	,		1. 00
1.00	HOUSEKEEPING			10 <u>5, 857</u> 105, 857		1	1.00
	I - N. Manchester RHC Salary		U	100, 607			
1.00	RURAL HEALTH CLINIC	88.00		1, 310, 189	<u>, </u>	I	1, 00
1.00	RURAL HEALTH CLINIC		 	1, 31 <u>0, 1</u> 89 1, 310, 189		1	1.00
	J - Kissinger RHC Salary		U	1, 310, 109	1		
1.00	RURAL HEALTH CLINIC II	88. 01		2, 717, 893			1, 00
1.00	NORAL HEALIN CLINIC II	— — 00. 01	 	2,71 <u>7,8</u> 93 2,717,893		1	1.00
500 00	Grand Total: Decreases		719, 727	7, 540, 308		1	500. 00
500.00	pranti rotar. Decreases	I	119,121	7, 540, 506	' I	I	500.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1310 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and 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, 518, 481 348, 500 22, 575 193, 521 0 22, 575 2.00 Land Improvements 2, 143, 602 2.00 23, 836, 744 0 3.00 193, 521 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 4, 433, 611 4, 548 4, 548 0 4.00 5.00 Fixed Equipment 3, 404, 159 24, 072 0 24, 072 205, 048 5.00 0 6.00 Movable Equipment 24, 767, 970 267, 118 267, 118 6.00 0 0 7.00 2, 659, 371 HIT designated Assets 89, 434 89, 434 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 62, 763, 938 601, 268 601, 268 553, 548 8.00 9.00 Reconciling Items 0 9.00 601, 268 553, 548 Total (line 8 minus line 9) 62, 763, 938 10.00 0 601, 268 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 169, 981 1.00 2.00 Land Improvements 314, 699 2. 00 2, 166, 177 24, 030, 265 . Buildings and Fixtures 3.00 12, 950, 778 3.00 4.00 Building Improvements 4, 438, 159 3, 962, 978 4.00 5.00 Fi xed Equipment 3, 223, 183 689, 367 5.00 25, 035, 088 19, 500, 634 6.00 Movable Equipment 6.00 1, 485, 645 7. 00 7.00 HIT designated Assets 2, 748, 805 Subtotal (sum of lines 1-7) 8.00 62, 811, 658 38, 904, 101 8.00

62, 811, 658

38, 904, 101

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

Health Financial Systems PA	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-1			
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1310			eri od:	Worksheet A-7		
				rom 01/01/2023 o 12/31/2023		pared:	
					5/24/2024 1: 3	2 pm	
	SUMMARY OF CAPITAL						
					-		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,		
					instructions)		
	9. 00	10. 00	11. 00	12. 00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00 CAP REL COSTS-BLDG & FLXT	2, 219, 530	140, 924	680, 161	0	5, 459	1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP	0	28, 112	C	0	0	2. 00	
3.00 Total (sum of lines 1-2)	2, 219, 530	169, 036	680, 161	0	5, 459	3. 00	
	SUMMARY O	F CAPITAL					
Cost Center Description	Other	Total (1) (sum					
	Capi tal -Relate	of cols. 9					
	d Costs (see	through 14)					
	instructions)	,					
	14.00	15. 00					

1. 00 2. 00 3. 00

Heal th	n Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		F		Period: From 01/01/2023 To 12/31/2023		pared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		·	1			
1.00	CAP REL COSTS-BLDG & FIXT	35, 027, 766		,,		0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	25, 035, 087				0	2. 00
3.00	Total (sum of lines 1-2)	60, 062, 853 668, 964 59, 393, 8				3. 00	
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C		
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
	·		Capi tal -Rel ate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 2, 098, 453	140, 924	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 032, 836		2. 00
3.00	Total (sum of lines 1-2)	0	U		0 3, 131, 289	169, 036	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	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	680, 161				2, 968, 181	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	00,		0	1, 094, 126	2. 00
3.00	Total (sum of lines 1-2)	680, 161	76, 363	5, 45	9 -1	4, 062, 307	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 PARKVIEW WABASH HOSPITAL, INC. Provider CCN: 15-1310

				T	o 12/31/2023	Date/Time Prep 5/24/2024 1:32	
				Expense Classification on	Worksheet A	372472024 1.32	z piii
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00	٥	2.00
3.00	Investment income - other		0		0.00	0	3. 00
	(chapter 2)						
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
5.00	expenses (chapter 8)		U		0.00	٩	5.00
6. 00	Rental of provider space by		0		0.00	o	6. 00
	suppliers (chapter 8)						
7.00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service	A	-435	OPERATION OF PLANT	7. 00	0	8. 00
0.00	(chapter 21)		100		7.00	Ĭ	0.00
9.00	Parking Lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physician	A-8-2	-464, 726			0	10.00
11 00	adjustment		0		0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	1, 546, 167			o	12. 00
	transactions (chapter 10)		.,			آ ا	
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00	Cafeteria-employees and guests		-246, 353	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others	1	0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	o	16. 00
	supplies to other than		· ·		0.00		10.00
	pati ents						
17. 00	Sale of drugs to other than	В	-89, 561	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
16.00	abstracts		Ü		0.00		10.00
19. 00	Nursing and allied health		0		0.00	o	19. 00
	education (tuition, fees,						
00.00	books, etc.)						00.00
20. 00 21. 00	Vending machines Income from imposition of	-	0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	Ĭ	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to	1					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	 *** Cost Center Deleted ***	65. 00		23. 00
23.00	therapy costs in excess of	703	0	Cost center bereted	05.00		23.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization (chapter 14)		Ω	 *** Cost Center Deleted ***	114. 00		25. 00
_5.00	physicians' compensation		0				_3. 50
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	이	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		^	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
∠1. UU	COSTS-MVBLE EQUIP		U	INCL GOSTS-WYDLE EQUIP	2.00		Z1. UU
28. 00	Non-physician Anesthetist]	0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	o	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		0				
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
52.00	Depreciation and Interest		0		3.00		52.00
33. 00	340B RETAIL	Α	-607	PHARMACY	15. 00	o	33. 00

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					5 12/31/2023	Date/lime Pre 5/24/2024 1:3	
				Expense Classification on	Worksheet A	072172021 1.0	Σ β
				To/From Which the Amount is			
				Toy I I om min on the yangant To	to bo haj aotoa		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	5651 5611161 56561 Pt. 611	1.00	2.00	3.00	4. 00	5. 00	
33. 01	Other Operating Revenue -	В		DI ETARY	10. 00	0	33. 01
	Di etary	_	.,			_	
33. 02	Other Operating Revenue -	В	-1.500	OPERATING ROOM	50.00	0	33. 02
	Operating Room	_	.,			_	
33. 03	Other Operating Revenue -	В	-24	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 03
	Radi ol ogy						
33. 04	Other Operating Revenue -	В	-500	SENI OR CARE	90. 01	0	33. 04
	Seni or Care						
33. 05	TV Depreciation	A	-16, 960	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 05
33.06	Lobbyi ng	A	-3, 941	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	Lobbyi ng	A	-2, 122	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	Lobbyi ng	l A	-22	RURAL HEALTH CLINIC II	88. 01	0	33. 08
33. 09	Depreciation - Old Hospital	l A		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 09
33. 10	Depreciation - Old Hospital	l A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 10
33. 11	Medicare Depreciation	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 11
33. 12	PPG Admin Physician Salaries	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	Li guor	l A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	Sponsorshi ps	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	Gift in Kind Distributions	A		CAP REL COSTS-BLDG & FIXT	1. 00	14	
33. 16	EMS Adjustment	A	·	AMBULANCE SERVICES	95. 00	0	33. 16
33. 17	HAF Expense Adjustment	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 20	Lobbyi ng	A		RURAL HEALTH CLINIC	88. 00	0	33. 20
33. 21	Lobbyi ng	A	·	RURAL HEALTH CLINIC II	88. 01	0	33. 21
33. 22	MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	MARKETING	A	·	DI ETARY	10. 00	0	33. 23
33. 24	MARKETING	A		SENI OR CARE	90. 01	0	33. 24
33. 25	EMPLOYEE BENEFIT XFER-	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 25
55. 20	PHYSICIANS	'`	, 100		1. 00		30.20
33. 26	340B RETAIL	A	-98	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 26
33. 27	HOSPITAL FUNDING TO FOUNDATION			RURAL HEALTH CLINIC II	88. 01	n	33. 27
50. 00	TOTAL (sum of lines 1 thru 49)		-2, 754, 672	1	23.01	Ü	50.00
50.00	(Transfer to Worksheet A,		2,,0.,072				30.00
	column 6, line 200.)						
(4) 5	,					l	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

15, 599, 493

14, 053, 326

5.00

 p	cor anno i aria, or 2, tho amoun				
			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	G	Parkvi ew Heal th	100.00	Parkvi ew Heal th	100.00	6. 00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	Home Office				100.00
	non-financial) specify:					

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

5.00

line 12.

TOTALS (sum of lines 1-4).

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

Heal th	lealth Financial Systems			PARKVIEW WABASH HOSPITAL, INC.						In Lieu of Form CMS-2552-		
STATEME	NT OF COSTS OF	SERVI CE	S FROM	RELATED	ORGANI ZA	TIONS A	ND HOME	Provi der CC	N: 15-1310	Peri od:	Worksheet A	N-8-1
OFFICE	COSTS									From 01/01/2023		
										To 12/31/2023		
										1.	5/24/2024 1	1:32 pm
	Net	Wkst. A	-7 Ref.									
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. (00									
	A. COSTS INCUR	RED AND	ADJUSTN	MENTS REC	UI RED AS	A RESU	ILT OF TRA	NSACTIONS WI	TH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:										
1.00	6, 152, 418		0									1. 00
2.00	-4, 606, 251		0									2.00
3.00	0		0									3.00
4.00	0		0									4.00
5.00	1, 546, 167											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as approi	ori ate)	are trans	sferred in de	etail to Wor	ksheet A, column	6. lines as	
										ganization or hom		st which
					9					cated in column 4		
	Related Orga	ani zati o	n(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.

	Home Office	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
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 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1310

					-	Γο 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	18, 751	18, 751	0	0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	404, 000	404, 000	0	0	O	2. 00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	10, 975	10, 975	0	0	0	3. 00
4.00	90. 01	SENI OR CARE	31, 000	31, 000	0	0	0	4. 00
5.00	91. 00	EMERGENCY	263, 222	0	263, 222	0	o	5. 00
6. 00	0. 00		1 0	0		0	o	6. 00
7. 00	0. 00		0	0	0	0	o	7. 00
8. 00	0. 00		0	0	0	0	o	8. 00
9. 00	0. 00		0	0	0	0	o	9. 00
10.00	0. 00		0	0	0	0	o	10.00
200.00			727, 948	464, 726	263, 222		o	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	1. 00
2.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	2. 00
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	3. 00
4.00	90. 01	SENI OR CARE	0	0	0	0	0	4. 00
5.00	91. 00	EMERGENCY	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	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1 00	1. 00	2.00 ADULTS & PEDIATRICS	15.00	16.00				1, 00
1.00				-	_			
2.00		ADULTS & PEDIATRICS		0				2.00
3.00		RADI OLOGY-DI AGNOSTI C		0				3.00
4.00		SENI OR CARE	0	0	_	0.7000		4. 00
5.00		EMERGENCY		0	_	0		5. 00
6.00	0.00			0	_	0		6. 00
7.00	0.00			0	_	0		7. 00
8.00	0. 00	1	0	0	_	0		8. 00
9.00	0.00		0	0		0		9. 00
10. 00	0. 00		1 ()	1 0		1 0	1	10.00
200.00	0.00			Ö	_	464, 726		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 1:32 pm 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 2, 968, 181 1 00 2, 968, 181 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 094, 126 1, 094, 126 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 476, 759 6, 476, 759 4.00 00500 ADMINISTRATIVE & GENERAL 329, 817 5 00 17, 288, 685 815 840 300 734 18 735 076 5 00 7.00 00700 OPERATION OF PLANT 1,099,771 346, 464 127, 713 126, 063 1, 700, 011 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 220, 785 220, 785 8.00 00900 HOUSEKEEPI NG 352, 688 63, 970 23, 580 127, 485 567, 723 9.00 9.00 10.00 01000 DI FTARY 113 293 27 044 27.433 241, 136 10 00 73.366 11.00 01100 CAFETERI A 524, 989 130, 969 48, 278 184, 640 888, 876 11.00 01300 NURSING ADMINISTRATION 532, 775 2, 078 747, 433 13.00 5, 638 206, 942 13.00 01500 PHARMACY 15.00 15.00 794, 182 108, 227 39, 894 306, 901 1, 249, 204 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2, 273, 695 298, 755 110, 127 751, 751 3, 434, 328 30.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 389, 358 2, 530, 490 1, 745, 267 289, 244 106, 621 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 C 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,085,886 243, 721 89.840 513, 922 2, 933, 369 54 00 06000 LABORATORY 2, 513, 296 2, 696, 164 60.00 133, 615 49, 253 60.00 66.00 06600 PHYSI CAL THERAPY 1, 104, 161 4, 219 1, 555 422, 964 1, 532, 899 66.00 06700 OCCUPATIONAL THERAPY 67 00 172, 398 9, 204 3, 393 66, 039 251, 034 67.00 68.00 06800 SPEECH PATHOLOGY 72, 211 767 283 27,662 100, 923 68.00 06900 ELECTROCARDI OLOGY 69.00 913, 623 109, 569 40, 389 312, 588 1, 376, 169 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 197.754 C 0 0 197, 754 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 989, 552 C 0 0 1, 989, 552 72 00 07300 DRUGS CHARGED TO PATIENTS 5, 457, 717 73.00 5.457.717 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 3, 268, 934 88 00 2, 676, 558 \cap 592.376 88. 01 08801 RURAL HEALTH CLINIC II 6, 198, 875 0 1, 347, 668 7, 546, 543 88.01 09000 CLI NI C 191, 111 90.00 142, 184 4, 372 1,612 42, 943 90.00 09001 SENI OR CARE 507, 041 81, 649 30, 097 193, 517 812, 304 90.01 90.01 1, 898, 706 09100 EMERGENCY 2, 679, 544 91.00 91.00 223, 433 82, 362 475,043 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95 00 0 0 0 0 Ω SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 61, 415, 158 2, 943, 022 1, 084, 853 6, 445, 112 61, 349, 079 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5,766 15, 264 5,626 26, 656 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 506, 263 192. 00 474, 616 C 31, 647 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 0 192. 01 0 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 192 02 0 Ω 0 0 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 C 0 0 0 192. 03 194.00 07950 FITNESS CENTER 0 0 194.00 0 194. 01 07951 FOUNDATI ON 0 9, 895 13, 542 194. 01 3.647 194. 02 07952 NEW DIRECTION 0 194, 02 0 C C 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 0 34, 023 194. 03 34,023 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 04 0 Ω 0 194. 05 07955 OCCUPATI ONAL HEALTH 0 0 0 194 05 0 C 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 61, 929, 563 1, 094, 126 61, 929, 563 202. 00 202.00 TOTAL (sum lines 118 through 201) 2.968.181 6, 476, 759

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

			11	0 12/31/2023	5/24/2024 1:3	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	_ p
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	1					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	18, 735, 076					5. 00
7.00 00700 OPERATION OF PLANT	737, 359	2, 437, 370				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	95, 763		316, 548			8. 00
9. 00 00900 HOUSEKEEPI NG	246, 243	86, 339		900, 305		9. 00
10. 00 01000 DI ETARY	104, 590	99, 021	0	37, 919	482, 666	10.00
11. 00 01100 CAFETERI A	385, 539	176, 767	0	67, 691	0	11. 00
13. 00 01300 NURSING ADMINISTRATION	324, 190	7, 609		2, 914	0	13. 00
15. 00 01500 PHARMACY	541, 827	146, 072		55, 937	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0.10,072		0	0	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>	91		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 489, 599	403, 226	84, 272	154, 412	482, 666	30.00
43. 00 04300 NURSERY	0	0		0	0	43. 00
ANCILLARY SERVICE COST CENTERS	٩		<u> </u>	٥		10.00
50. 00 05000 OPERATING ROOM	1, 097, 570	390, 389	42, 050	149, 496	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,0,7,0,0	070, 007	12,000	117, 170	0	52.00
53. 00 05300 ANESTHESI OLOGY		0		0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 272, 314	328, 948	67, 808	125, 967	0	54.00
60. 00 06000 LABORATORY	1, 169, 429	180, 339		69, 059	0	60.00
66. 00 06600 PHYSI CAL THERAPY	664, 877	5, 694		2, 180	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	108, 883	12, 423		4, 757	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	43, 774	1, 035		396	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	596, 897	147, 884	1	56, 631	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	85, 773	147, 884	1	30, 031	0	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	862, 944	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 367, 219	0		0	0	73.00
OUTPATIENT SERVICE COST CENTERS	2, 307, 219	U	ų o	U	0	/3.00
88. 00 08800 RURAL HEALTH CLINIC	1, 417, 861	0	0	٥	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC 1	3, 273, 207	0		0	0	88. 01
90. 00 09000 CLINIC		5, 901	/	2 240	0	90.00
	82, 892			2, 260		•
90. 01 09001 SENI OR CARE 91. 00 09100 EMERGENCY	352, 327	110, 201		42, 201	0	90. 01
	1, 162, 220	301, 566	121, 927	115, 482	U	91.00
						92.00
OTHER REIMBURSABLE COST CENTERS				ما	0	05 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS						112 00
113. 00 11300 INTEREST EXPENSE	10 402 207	2 402 414	21/ 540	007 202	400 ///	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 483, 297	2, 403, 414	316, 548	887, 302	482, 666	1118.00
NONREI MBURSABLE COST CENTERS	14.5(0)	00 (04		7 000		100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 562	20, 601	0	7, 889		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	219, 586	Ü		0		192. 00
192. 01 19201 PV WABASH HEALTH CLINC-CASS	0	Ü		0		192. 01
192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH	0	Ü		0		192. 02
192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER	0	Ü	0	0		192. 03
194. 00 07950 FITNESS CENTER	0	10.055	0	0		194. 00
194. 01 07951 FOUNDATION	5, 874	13, 355		5, 114		194. 01
194. 02 07952 NEW DIRECTION	0	0	<u>0</u>	0		194. 02
194. 03 07953 COMMUNITY & VOLUNTEER SERVICES	14, 757	0	<u>0</u>	0		194. 03
194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS	0	0	<u>0</u>	0		194. 04
194. 05 07955 OCCUPATI ONAL HEALTH	0	0	0 ا	0	0	194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	18, 735, 076	2, 437, 370	316, 548	900, 305	482, 666	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1310

				10) 12/31/2023	5/24/2024 1: 3	
	Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	Subtotal	
	, and the second		ADMI NI STRATI ON		RECORDS &		
					LI BRARY		
		11. 00	13. 00	15. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 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	D1100 CAFETERI A	1, 518, 873					11. 00
13. 00	01300 NURSING ADMINISTRATION	63, 908	1, 146, 054				13.00
15. 00	01500 PHARMACY	94, 752	o	2, 088, 283			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	o	0	O		16. 00
Ī	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	345, 944	567, 414	0	0	6, 961, 861	30.00
43.00	04300 NURSERY	0	o	0	0	0	43.00
7	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATING ROOM	142, 869	234, 318	0	0	4, 587, 182	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	o	0	O	0	52.00
53.00	05300 ANESTHESI OLOGY	0	o	0	O	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	230, 959	o	0	0	4, 959, 365	54.00
	06000 LABORATORY	0	o	0	o	4, 114, 991	60.00
66.00	06600 PHYSI CAL THERAPY	99, 564	o	0	O	2, 305, 214	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	91, 051	o	0	o	468, 148	1
	06800 SPEECH PATHOLOGY	10, 240	o	0	o	156, 368	1
	06900 ELECTROCARDI OLOGY	117, 823	o	0	O	2, 295, 404	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	0	O	283, 527	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	0	o	2, 852, 496	1
1	07300 DRUGS CHARGED TO PATIENTS	0	o	2, 088, 283	o	9, 913, 219	
-	OUTPATIENT SERVICE COST CENTERS				'		
	08800 RURAL HEALTH CLINIC	0	0	0	0	4, 686, 795	88. 00
	08801 RURAL HEALTH CLINIC II	0	o	0	o	10, 819, 750	1
	09000 CLI NI C	18, 753	o	0	o	300, 917	90.00
	09001 SENLOR CARE	93, 025	o	0	o	1, 410, 058	1
	09100 EMERGENCY	209, 985	344, 322	0	o	4, 935, 046	
1	09200 OBSERVATION BEDS (NON-DISTINCT PART					, ,	92.00
	OTHER REIMBURSABLE COST CENTERS			'	'		
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
9	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 518, 873	1, 146, 054	2, 088, 283	0	61, 050, 341	118. 00
1	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	66, 708	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	o	0	0	725, 849	192. 00
192. 01	19201 PV WABASH HEALTH CLINC-CASS	0	o	0	0	0	192. 01
192. 02	19202 PV WABASH HEALTH CLINC-N.MANCH	0	o	0	0	0	192. 02
192. 03	19203 PV WABASH HEALTH CLINC-KISSINGER	0	o	0	0	0	192. 03
194.00	07950 FITNESS CENTER	0	0	0	0	0	194. 00
194. 01	07951 FOUNDATION	0	0	0	o	37, 885	194. 01
	07952 NEW DIRECTION	0	ol	0	o		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	0	ol	0	o	48, 780	194. 03
194.04	07956 OTHER NONREIMBURSABLE COST CENTERS	0	o	0	o		194. 04
194.05	07955 OCCUPATIONAL HEALTH	0	o	0	o		194. 05
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	ol	0	O	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 518, 873	1, 146, 054	2, 088, 283	o	61, 929, 563	
			-		•		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1310 Peri od: Worksheet B From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 961, 861 30.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 4, 587, 182 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 53.00 0000000000 53.00 4, 959, 365 05400 RADI OLOGY-DI AGNOSTI C 54 00 54 00 06000 LABORATORY 60.00 4, 114, 991 60.00 06600 PHYSI CAL THERAPY 2, 305, 214 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 468, 148 67.00 06800 SPEECH PATHOLOGY 156, 368 68 00 68 00 06900 ELECTROCARDI OLOGY 69.00 2, 295, 404 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 283, 527 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 852, 496 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 913, 219 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88 00 4, 686, 795 0 10, 819, 750 88.01 08801 RURAL HEALTH CLINIC II 88.01 09000 CLI NI C 90 00 300.917 90 00 90.01 09001 SENI OR CARE 0 1, 410, 058 90.01 09100 EMERGENCY 0 91.00 4, 935, 046 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 61, 050, 341 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 66, 708 000000000000000 192.00 19200 PHYSICIANS' PRIVATE OFFICES 725, 849 192. 00 192. 01 19201 PV WABASH HEALTH CLINC-CASS 192. 01 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 192. 02 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 192. 03 0 194.00 07950 FITNESS CENTER 194. 00 194. 01 07951 FOUNDATI ON 194. 01 37, 885 194. 02 07952 NEW DIRECTION 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 194. 03 48, 780 194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 194. 04 194. 05 07955 OCCUPATI ONAL HEALTH 194. 05 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 61, 929, 563 202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS PARKVIEW WABASH HOSPITAL, INC. Provider CCN: 15-1310

				To	12/31/2023	Date/Time Pre 5/24/2024 1:3	pared:
			CAPI TAL REI	LATED COSTS		3/24/2024 1.3	Z piii
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DELAKTIMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	1		1	T		4 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	o	0	4.00
	00500 ADMINISTRATIVE & GENERAL	2, 741, 536	815, 840	- 1	3, 858, 110	0	5. 00
	00700 OPERATION OF PLANT	0	346, 464	127, 713	474, 177	0	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
	00900 HOUSEKEEPI NG	0	63, 970	1	87, 550	0	9. 00
	01000 DI ETARY 01100 CAFETERI A	0	73, 366 130, 969	1	100, 410 179, 247	0	10. 00 11. 00
	01300 NURSING ADMINISTRATION	0	5, 638	1	7, 716	0	13.00
	01500 PHARMACY	0	108, 227	1	148, 121	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	1	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	18, 885		1	427, 767	0	30.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
	05000 OPERATING ROOM	0	289, 244	106, 621	395, 865	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	0	o	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	243, 721	1	333, 561	0	54.00
60.00	06000 LABORATORY	0	133, 615		182, 868	0	60.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	4, 219 9, 204	1	5, 774 12, 597	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	767	1	1, 050	0	68.00
	06900 ELECTROCARDI OLOGY	0	109, 569	1	149, 958	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	69, 478	0	0	69, 478	0	88. 00
	08801 RURAL HEALTH CLINIC II	404, 996		- 1	404, 996	0	88. 01
	09000 CLI NI C	0	4, 372		5, 984	0	90.00
	09001 SENI OR CARE	0	81, 649	30, 097	111, 746	0	90. 01
	09100 EMERGENCY	0	223, 433	82, 362	305, 795	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	0	o	0	95. 00
75.00	SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>	<u> </u>	0	75.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 234, 895	2, 943, 022	1, 084, 853	7, 262, 770	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			20, 890		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 PV WABASH HEALTH CLINC-CASS	327, 624	0	0	327, 624		192. 00 192. 01
	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	ol		192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	0	0	ō		192. 03
194.00	07950 FITNESS CENTER	0	0	0	o	0	194. 00
	07951 FOUNDATI ON	0	9, 895	3, 647	13, 542		194. 01
	07952 NEW DIRECTION	0	0	0	0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES 07956 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 03 194. 04
	07955 OCCUPATIONAL HEALTH			0	0		194. 04
200.00	Cross Foot Adjustments				ol		200. 00
201.00	, ,		0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 562, 519	2, 968, 181	1, 094, 126	7, 624, 826	0	202. 00

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

						5/24/2024 1: 3	2 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		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	3, 858, 110					5. 00
7.00	00700 OPERATION OF PLANT	151, 845	626, 022				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 721	l				8. 00
9.00	00900 HOUSEKEEPI NG	50, 709	22, 176		160, 435		9. 00
10.00	01000 DI ETARY	21, 538			6, 757	154, 138	
11. 00	01100 CAFETERI A	79, 394			12, 063	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	66, 761	1, 954		519		
15. 00	01500 PHARMACY	111, 579	1		9, 968		15. 00
16. 00		111, 579	l		9, 900 N	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1 0		0	U	0	16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	201 751	100 5//		07.544	454.400	
30.00	03000 ADULTS & PEDIATRICS	306, 754	l		27, 516		30. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	226, 023	100, 269	2, 620	26, 640		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	262, 009	84, 488	4, 224	22, 447	0	54.00
60.00	06000 LABORATORY	240, 821	46, 319	0	12, 306	0	60.00
66.00	06600 PHYSI CAL THERAPY	136, 919	1, 462	0	389	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	22, 422	3, 191	0	848	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	9, 014			71	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	122, 919			10, 092	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 663	l		0	Ö	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	177, 707	ĺ		0	•	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	487, 483			0		73.00
73.00	OUTPATIENT SERVICE COST CENTERS	407, 403				0	73.00
88. 00	08800 RURAL HEALTH CLINIC	291, 981	0	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	674, 037			0		88. 01
90.00	09000 CLINIC	17, 070	1	_	403	0	90.00
		1					
90. 01	09001 SENI OR CARE	72, 555			7, 520	0	90. 01
91.00	09100 EMERGENCY	239, 337	77, 455	7, 596	20, 579	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113. 00
118.00		3, 806, 261	617, 301	19, 721	158, 118	154, 138	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 381	5, 291	0	1, 406	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	45, 219	0	0	0	0	192. 00
192. 01	19201 PV WABASH HEALTH CLINC-CASS	0	0	0	0	0	192. 01
192. 02	19202 PV WABASH HEALTH CLINC-N. MANCH	0	0	0	0	0	192. 02
	19203 PV WABASH HEALTH CLINC-KISSINGER	0	Ö	•	0		192. 03
	07950 FI TNESS CENTER	0	0		0		194. 00
	07951 FOUNDATION	1, 210	1	_	911		194. 01
	07952 NEW DIRECTION	1,210	0, 430		0		194. 02
	07953 COMMUNITY & VOLUNTEER SERVICES	3, 039		_	0		194. 02
	107956 OTHER NONREIMBURSABLE COST CENTERS	3,039			0	•	194. 03
		0		_	0		
	07955 OCCUPATI ONAL HEALTH	0		0	0		194. 05
200.00	, , , , , , , , , , , , , , , , , , ,	_	_	_	_	_	200.00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 858, 110	626, 022	19, 721	160, 435	154, 138	J202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1310

Period: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/24/2024 1:32 pm Cost Center Description CAFETERI A NURSI NG PHARMACY MEDI CAL Subtotal ADMI NI STRATI ON RECORDS & LI BRARY 11. 00 13.00 15.00 24.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 316, 105 11.00 01300 NURSING ADMINISTRATION 13.00 13.300 13.00 90, 250 01500 PHARMACY 15.00 19, 720 326, 937 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 71, 997 1, 141, 671 30.00 44, 683 0 0 0 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 29, 734 18, 452 0 0 799, 603 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 Ω 52.00 53.00 05300 ANESTHESI OLOGY C 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 48,067 0 754, 796 54.00 06000 LABORATORY 0 482, 314 60.00 0 60.00 06600 PHYSI CAL THERAPY 0 66.00 20.721 0 165, 265 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 18, 949 0 0 58,007 67.00 06800 SPEECH PATHOLOGY 68.00 2, 131 0 0 12, 532 68.00 345, 473 69 00 06900 ELECTROCARDI OLOGY 0 0 69 00 24.521 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 C 17, 663 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 177, 707 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 326, 937 0 814, 420 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 0 361, 459 88 00 08801 RURAL HEALTH CLINIC II 0 1, 079, 033 88. 01 0 0 0 88.01 90 00 09000 CLI NI C 3.903 Ω 0 28, 876 90 00 0 09001 SENI OR CARE 90.01 19, 360 239, 485 90.01 91.00 09100 EMERGENCY 43, 702 27, 115 0 0 721, 579 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 90, 250 7, 199, 8<u>83</u> 118. 00 316, 105 326, 937 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 29, 968 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 372, 843 192. 00 0 0 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 192.01 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 00000 0 0 0 0 0 0 0 0 0 192. 02 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 192. 03 194. 00 07950 FITNESS CENTER 0 0 194.00 0 194. 01 07951 FOUNDATI ON 0 0 19, 093 194. 01 194. 02 07952 NEW DIRECTION 0 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 3, 039 194. 03 0 0 194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 194, 04 C 0 194. 05 07955 OCCUPATI ONAL HEALTH 0 0 0 194. 05 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201, 00 0 0 90, 250 202.00 TOTAL (sum lines 118 through 201) 316, 105 326, 937 7, 624, 826 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1310 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 141, 671 30.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 799, 603 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 05300 ANESTHESI OLOGY 53.00 0000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 754, 796 54 00 06000 LABORATORY 60.00 482, 314 60.00 06600 PHYSI CAL THERAPY 165, 265 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 58, 007 67.00 06800 SPEECH PATHOLOGY 12, 532 68 00 68 00 06900 ELECTROCARDI OLOGY 69.00 345, 473 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 17, 663 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 177, 707 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 814, 420 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88 00 361, 459 0 1, 079, 033 88.01 08801 RURAL HEALTH CLINIC II 88.01 09000 CLI NI C 90 00 28, 876 90 00 90.01 09001 SENI OR CARE 0 239, 485 90.01 09100 EMERGENCY 0 91.00 721, 579 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 7, 199, 883 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 190.00 0 29.968 0000000000000 372, 843 192. 00 192. 01 19201 PV WABASH HEALTH CLINC-CASS 192. 01 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 192. 02 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 192. 03 0 194.00 07950 FITNESS CENTER 194. 00 194. 01 07951 FOUNDATI ON 19, 093 194. 01 194. 02 07952 NEW DIRECTION 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 194. 03 3, 039 194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS C 194. 04 194. 05 07955 OCCUPATI ONAL HEALTH 194. 05 0 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 7, 624, 826 202.00

	<i>y</i>	ARKVIEW WABASH		1-		u of Form CMS-	
COST ALL	OCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2023	Worksheet B-1	
					o 12/31/2023		
		CAPITAL REL	ATED COSTS			5/24/2024 1:3	2 pm
		CAFTIAL KLL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FLXT	77, 395	l				1.00
	0200 CAP REL COSTS-MVBLE EQUIP		77, 395 0	1	,		2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL	21, 273		, ,		43, 194, 487	4. 00 5. 00
	0700 OPERATION OF PLANT	9,034	9, 034			1, 700, 011	1
8.00 0	0800 LAUNDRY & LINEN SERVICE	0	0	C	0	220, 785	8. 00
	0900 HOUSEKEEPI NG	1, 668				567, 723	1
	1000 DI ETARY 1100 CAFETERI A	1, 913	1			241, 136	
	1300 NURSING ADMINISTRATION	3, 415 147	l ·				
	1500 PHARMACY	2, 822				1	
	1600 MEDICAL RECORDS & LIBRARY	0	0	C			1
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	7, 790	i .				
	4300 NURSERY NCILLARY SERVICE COST CENTERS	0	0	C	0	0	43. 00
	5000 OPERATING ROOM	7, 542	7, 542	988, 132	2 0	2, 530, 490	50.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	1			1
	5300 ANESTHESI OLOGY	0	0	C	0		
	5400 RADI OLOGY-DI AGNOSTI C	6, 355	1			2, 933, 369	
	6000 LABORATORY 6600 PHYSI CAL THERAPY	3, 484 110	1		0	2, 696, 164 1, 532, 899	1
	6700 OCCUPATIONAL THERAPY	240	l			251, 034	•
	6800 SPEECH PATHOLOGY	20		70, 201		100, 923	•
	6900 ELECTROCARDI OLOGY	2, 857	2, 857	793, 301	0	1, 376, 169	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	_	197, 754	•
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0				1
	7300 DRUGS CHARGED TO PATIENTS UTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	5, 457, 717	73. 00
	8800 RURAL HEALTH CLINIC	0	0	1, 503, 362	2 0	3, 268, 934	88. 00
	8801 RURAL HEALTH CLINIC II	0	0	3, 420, 188	0	7, 546, 543	88. 01
	9000 CLINIC	114					1
	9001 SENI OR CARE 9100 EMERGENCY	2, 129 5, 826					1
	9200 OBSERVATION BEDS (NON-DISTINCT PART	3,020	3, 020	1, 203, 300	0	2,077,344	92. 00
	THER REIMBURSABLE COST CENTERS	I.					72.00
	9500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
	PECIAL PURPOSE COST CENTERS	I	I	Γ		I	1440 00
113.00 1	1300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	76, 739	76, 739	16, 356, 742	-18, 735, 076	42, 614, 003	113.00
	ONREI MBURSABLE COST CENTERS	70,737	70,737	10, 330, 742	- 10, 733, 070	42, 014, 003	1110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	398	C	0	26, 656	190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	0	0	80, 316			
	9201 PV WABASH HEALTH CLINC-CASS	0	0	C	0		192. 01
	9202 PV WABASH HEALTH CLINC-N. MANCH	0 0	0		0		192. 02 192. 03
	9203 PV WABASH HEALTH CLINC-KISSINGER 7950 FITNESS CENTER	0	0		-		194. 00
	7951 FOUNDATION	258	· ·		_		194. 01
	7952 NEW DIRECTION	0	0	C	0		194. 02
	7953 COMMUNITY & VOLUNTEER SERVICES	0	0	C	0		194. 03
	7956 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	l	194. 04
200.00	7955 OCCUPATIONAL HEALTH Cross Foot Adjustments	0	U		, 0	U	194. 05 200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 968, 181	1, 094, 126	6, 476, 759)	18, 735, 076	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	38. 351069	14. 136908	0. 394034		0. 433738	
204. 00	Cost to be allocated (per Wkst. B, Part II)				,	3, 858, 110	204.00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000		0. 089320	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1310 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (MEALS SERVED) PLANT LINEN SERVICE (HOURS) (SQUARE FEET) (POUNDS OF LAUNDR) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 47,088 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 27, 725 8.00 00900 HOUSEKEEPI NG 9.00 1.668 45, 420 9.00 1, 913 10.00 01000 DI ETARY 1,913 0 16,680 10.00 11.00 01100 CAFETERI A 3, 415 12, 311 3.415 0 11.00 01300 NURSING ADMINISTRATION 13.00 147 13.00 147 C 0 518 15.00 01500 PHARMACY 2,822 43 2,822 0 768 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2, 804 30.00 7, 790 7, 381 7, 790 16, 680 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7,542 3, 683 7, 542 1, 158 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 53.00 C 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 355 5, 939 6, 355 1,872 54.00 06000 LABORATORY 3 484 60 00 C 3 484 0 60 00 0 66.00 06600 PHYSI CAL THERAPY 110 C 110 807 66.00 06700 OCCUPATIONAL THERAPY 67.00 240 240 0 0 0 738 67.00 68 00 06800 SPEECH PATHOLOGY 20 68 00 Ω 20 83 69.00 06900 ELECTROCARDI OLOGY 2,857 C 2,857 955 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 0 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 88.00 0 0 88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 88.01 90.00 09000 CLI NI C 152 90 00 114 Ω 114 90.01 09001 SENI OR CARE 2, 129 2, 129 0 754 90.01 09100 EMERGENCY 91.00 5,826 10,679 5,826 1,702 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 95.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 16, 680 12, 311 118. 00 118.00 46, 432 27, 725 44, 764 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 398 398 0 190. 00 0 192.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192. 01 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 0 0 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 192. 02 0 0 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 0 192. 03 194. 00 07950 FI TNESS CENTER 0 0 194.00 C 0 194. 01 07951 FOUNDATI ON 258 0 0 194. 01 258 194.02 07952 NEW DIRECTION 0 0 0 194. 02 0 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES 0 0 194, 03 C 0 194. 04 07956 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194. 04 194. 05 07955 OCCUPATIONAL HEALTH 0 0 0 0 194. 05 Cross Foot Adjustments 200.00 200.00 201 00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 437, 370 316, 548 900, 305 482, 666 1, 518, 873 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 51. 762020 11. 417421 19. 821775 28. 936811 123. 375274 203. 00 203.00 204.00 Cost to be allocated (per Wkst. B, 626,022 19, 721 160, 435 154, 138 316, 105 204. 00 Part II) 25. 676631 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 13. 294725 0.711307 3.532255 9.240887 Π 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

In Lieu of Form CMS-2552-10 Health Financial Systems PARKVIEW WABASH HOSPITAL, INC. COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1310 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm Cost Center Description NURSI NG PHARMACY MEDI CAL ADMI NI STRATI ON RECORDS & (COSTED REQUIS.) LI BRARY (DIRECT NRS (GROSS REV) ING HR) 15.00 13.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 117, 820 13.00 15.00 01500 PHARMACY 43, 902 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 0 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 58, 333 0 0 30.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24,089 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 0 54 00 0 60.00 06000 LABORATORY 0000 0 60.00 06600 PHYSI CAL THERAPY 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 Ω 06900 ELECTROCARDI OLOGY 0 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 43, 902 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88 00 0 0 88 00 08801 RURAL HEALTH CLINIC II 0 0 88.01 88.01 0 09000 CLI NI C 0 90 00 0 C 90 00 09001 SENIOR CARE 0 90.01 90.01 09100 EMERGENCY 91.00 35, 398 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 117,820 43, 902 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 C 192. 00 192. 01 19201 PV WABASH HEALTH CLINC-CASS 0 0 192.01 0 192. 02 19202 PV WABASH HEALTH CLINC-N. MANCH 0 0 0 192. 02 192. 03 19203 PV WABASH HEALTH CLINC-KISSINGER 0 192. 03 C 194.00 07950 FITNESS CENTER C 194.00 194. 01 07951 FOUNDATION 0 194. 01 0 0 194. 02 07952 NEW DIRECTION 0 194. 02 194. 03 07953 COMMUNITY & VOLUNTEER SERVICES C 0 194. 03 194. 04 07956 OTHER NONREI MBURSABLE COST CENTERS 0 C 0 194.04 194. 05 07955 OCCUPATIONAL HEALTH 0 0 194.05 200 00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 146, 054 2,088,283 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 9. 727160 47. 566922 203. 00 0.000000 204.00 Cost to be allocated (per Wkst. B, 90, 250 326, 937 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.765999 7.446973 0.000000 205.00 II)

206. 00

207.00

206,00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC. In			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-1310	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prep 5/24/2024 1:32	
		Title	XVIII	Hospi tal	Cost	
				Costs		

						5/24/2024 1:3	2 pm
			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	
	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	O ADULTS & PEDIATRICS	6, 961, 861		6, 961, 86°	0	0	
43.00 0430		0		(0	0	43. 00
ANCI I	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	4, 587, 182		4, 587, 182	0	0	50.00
52. 00 0520	O DELIVERY ROOM & LABOR ROOM	0		(0	0	52.00
53.00 0530	O ANESTHESI OLOGY	0			0	0	53.00
54. 00 0540	O RADI OLOGY-DI AGNOSTI C	4, 959, 365		4, 959, 36!	0	0	54.00
60.00 06000	O LABORATORY	4, 114, 991		4, 114, 99°	0	0	60.00
66. 00 0660	O PHYSI CAL THERAPY	2, 305, 214	0	2, 305, 214	1 0	0	66.00
67. 00 0670	O OCCUPATI ONAL THERAPY	468, 148	0	468, 148	0	0	67.00
68. 00 0680	O SPEECH PATHOLOGY	156, 368	0	156, 368	0	0	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	2, 295, 404		2, 295, 404	1 0	0	69. 00
71. 00 0710	MEDICAL SUPPLIES CHARGED TO PATIENT	283, 527		283, 52	0	0	71.00
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS	2, 852, 496		2, 852, 496	0	0	72.00
73.00 0730	D DRUGS CHARGED TO PATIENTS	9, 913, 219		9, 913, 219	9 0	0	73.00
OUTPA	ATIENT SERVICE COST CENTERS						
88. 00 0880	O RURAL HEALTH CLINIC	4, 686, 795		4, 686, 79	0	0	88. 00
88. 01 0880	1 RURAL HEALTH CLINIC II	10, 819, 750		10, 819, 750	0	0	88. 01
90.00 0900	O CLI NI C	300, 917		300, 91	0	0	90.00
90. 01 0900	1 SENI OR CARE	1, 410, 058		1, 410, 058	0	0	90. 01
91.00 0910	O EMERGENCY	4, 935, 046		4, 935, 046	0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	2, 135, 284		2, 135, 28	1	0	92.00
OTHER	R REIMBURSABLE COST CENTERS						1
95. 00 0950	O AMBULANCE SERVICES	0		(0	0	95. 00
SPECI	IAL PURPOSE COST CENTERS				*		
113. 00 1130	O I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	63, 185, 625	0	63, 185, 62	0	0	200. 00
201. 00	Less Observation Beds	2, 135, 284		2, 135, 28	1	0	201. 00
202.00	Total (see instructions)	61, 050, 341	0	61, 050, 34°	0	0	202. 00
•				•	*	-	•

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

Health Financial Systems		ARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-1		
СОМРИТ	TATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/24/2024 1:3	
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		(00	7.00	0.00	0.00	Ratio	
	INDATI ENT DOUTING CEDALCE COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 000 207		7 000 00	.7		30.00
30.00	03000 ADULTS & PEDI ATRI CS	7, 903, 297		7, 903, 29			43. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	l 0			0		43.00
50. 00	05000 OPERATING ROOM	2, 251, 574	21, 631, 419	23, 882, 99	0. 192069	0. 000000	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 231, 374	21,031,419	23, 002, 99	0. 000000	0.00000	
53. 00	05300 ANESTHESI OLOGY	0	0		0.000000	0.00000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 424, 490	37, 928, 359	39, 352, 84		0.00000	
60.00	06000 LABORATORY	2, 707, 583	29, 834, 106			0.00000	
66. 00	06600 PHYSI CAL THERAPY	436, 734	5, 564, 942			0.00000	
67. 00	06700 OCCUPATI ONAL THERAPY	347, 149	573, 862			0.00000	
68. 00	06800 SPEECH PATHOLOGY	100, 227	385, 754			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	2, 072, 805	9, 979, 742			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	249, 454	3, 345, 682			0. 000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	852, 087	9, 850, 942				
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 374, 183	34, 763, 689			0. 000000	
	OUTPATIENT SERVICE COST CENTERS		2.,,,	1 20/101/01			1
88. 00	08800 RURAL HEALTH CLINIC	0	2, 929, 947	2, 929, 94	.7		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	9, 570, 478	9, 570, 47	8		88. 01
90.00	09000 CLI NI C	9, 116	1, 512, 432	1, 521, 54	8 0. 197770	0.000000	90.00
90. 01	09001 SENI OR CARE	0	3, 137, 373	3, 137, 37	0. 449439	0.000000	90. 01
91.00	09100 EMERGENCY	829, 612	42, 892, 918	43, 722, 53	0. 112872	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	20, 224	2, 846, 985	2, 867, 20	0. 744726	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS]
95.00	09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		22, 578, 535	216, 748, 630	239, 327, 16	5		200. 00
201.00							201. 00
202.00	Total (see instructions)	22, 578, 535	216, 748, 630	239, 327, 16	5		202. 00

				To 12/31/2023	Date/Time Prepare 5/24/2024 1:32 pm	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS					. 00
43. 00	04300 NURSERY				43.	. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM	0. 000000				. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				. 00
60.00	06000 LABORATORY	0. 000000				. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000				. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				. 00
	06800 SPEECH PATHOLOGY	0. 000000				. 00
	06900 ELECTROCARDI OLOGY	0. 000000				. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.	. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	. 00
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC					. 00
	08801 RURAL HEALTH CLINIC II					. 01
	09000 CLI NI C	0. 000000				. 00
	09001 SENI OR CARE	0. 000000				. 01
91.00	09100 EMERGENCY	0. 000000			91.	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.	. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVI CES	0. 000000			95.	. 00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 I NTEREST EXPENSE				113.	. 00
200.00					200.	
201.00	Less Observation Beds				201.	
202.00	Total (see instructions)				202.	. 00

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-1310	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/24/2024 1:3	pared: 2 pm
		Ti t	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limi Adj.	t Total Cost	s RCE Di sal I owance	Total Costs	

				e xi x	поѕрі таі	PP3	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,			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	6, 961, 861		6, 961, 861	0	6, 961, 861	30.00
43.00	04300 NURSERY	0		0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 587, 182		4, 587, 182	0	4, 587, 182	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 959, 365		4, 959, 365	0	4, 959, 365	54.00
60.00	06000 LABORATORY	4, 114, 991		4, 114, 991	0	4, 114, 991	60.00
66.00	06600 PHYSI CAL THERAPY	2, 305, 214	0	2, 305, 214	0	2, 305, 214	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	468, 148	0	468, 148	0	468, 148	67. 00
68.00	06800 SPEECH PATHOLOGY	156, 368	0	156, 368	0	156, 368	68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 295, 404		2, 295, 404	0	2, 295, 404	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	283, 527		283, 527	0	283, 527	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 852, 496		2, 852, 496	0	2, 852, 496	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 913, 219		9, 913, 219	0	9, 913, 219	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	4, 686, 795		4, 686, 795	0	4, 686, 795	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	10, 819, 750		10, 819, 750	0	10, 819, 750	88. 01
90.00	09000 CLI NI C	300, 917		300, 917	0	300, 917	90.00
90. 01	09001 SENI OR CARE	1, 410, 058		1, 410, 058	0	1, 410, 058	90. 01
91.00	09100 EMERGENCY	4, 935, 046		4, 935, 046	0	4, 935, 046	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 135, 284		2, 135, 284		2, 135, 284	92. 00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>					
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS			<u>'</u>			
113.00	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	63, 185, 625	0	63, 185, 625	0	63, 185, 625	200. 00
201.00		2, 135, 284		2, 135, 284		2, 135, 284	
202.00	1 1	61, 050, 341	l .				
			•				

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

Health Fir	nanciai Systems Pi	ARKVIEW WABASH I	HUSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUTATI (ON OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
					From 01/01/2023		
					To 12/31/2023		pared:
			T: ±1	- VIV	11: 4-1	5/24/2024 1: 32 pm PPS	
				e XIX	Hospi tal	PP5	
	0 1 0 1 1		Charges	T		TEEDA	
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpati ent	
		(00	7.00	0.00	0.00	Ratio	
LND	ATTENT POUT NE CERVI OF COCT OFFITERS	6. 00	7. 00	8. 00	9. 00	10.00	
	PATIENT ROUTINE SERVICE COST CENTERS	7 000 007		7 000 00	¬I		00.00
	000 ADULTS & PEDI ATRI CS	7, 903, 297		7, 903, 29			30. 00
	300 NURSERY	0			0		43. 00
	ILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	2, 251, 574	21, 631, 419				
	200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000		
	300 ANESTHESI OLOGY	0	0		0. 000000		
	100 RADI OLOGY-DI AGNOSTI C	1, 424, 490	37, 928, 359				
	000 LABORATORY	2, 707, 583	29, 834, 106				
66. 00 066	00 PHYSI CAL THERAPY	436, 734	5, 564, 942	6, 001, 67	6 0. 384095	0.000000	66. 00
	OO OCCUPATIONAL THERAPY	347, 149	573, 862	921, 01	1 0. 508298	0.000000	67. 00
68. 00 068	300 SPEECH PATHOLOGY	100, 227	385, 754	485, 98	1 0. 321757	0.000000	68. 00
69.00 069	POO ELECTROCARDI OLOGY	2, 072, 805	9, 979, 742	12, 052, 54	7 0. 190450	0.000000	69. 00
71. 00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	249, 454	3, 345, 682	3, 595, 13	6 0. 078864	0.000000	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	852, 087	9, 850, 942	10, 703, 02	9 0. 266513	0.000000	72. 00
73. 00 073	BOO DRUGS CHARGED TO PATIENTS	3, 374, 183	34, 763, 689	38, 137, 87	2 0. 259931	0.000000	73. 00
OUT	PATIENT SERVICE COST CENTERS						1
88. 00 088	BOO RURAL HEALTH CLINIC	0	2, 929, 947	2, 929, 94	7 1. 599618	0.000000	88. 00
88. 01 088	BO1 RURAL HEALTH CLINIC II	o	9, 570, 478	9, 570, 47	8 1.130534	0.000000	88. 01
90.00 090	DOO CLINIC	9, 116	1, 512, 432	1, 521, 54	8 0. 197770	0.000000	90.00
90. 01 090	001 SENI OR CARE	o	3, 137, 373			0. 000000	90. 01
91. 00 091	00 EMERGENCY	829, 612	42, 892, 918			0. 000000	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	20, 224	2, 846, 985				
	IER REI MBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0	0		0. 000000	0.000000	95. 00
	CIAL PURPOSE COST CENTERS	-1					1
	300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	22, 578, 535	216, 748, 630	239, 327, 16	5		200. 00
201.00	Less Observation Beds	22,070,000	210, 710, 000	207, 027, 10			201. 00
202. 00	Total (see instructions)	22, 578, 535	216, 748, 630	239, 327, 16	5		202. 00
202.00	Total (300 Histi dott oils)	22, 370, 333	210, 740, 030	207, 027, 10	∽	i I	1202.00

			To 12/31/2023	Date/Time Prepared: 5/24/2024 1:32 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 192069			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 126023			54. 00
60. 00 06000 LABORATORY	0. 126453			60. 00
66. 00 06600 PHYSI CAL THERAPY	0. 384095			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 508298			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 321757			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 190450			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 078864			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 266513			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 259931			73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	1. 599618			88. 00
88.01 08801 RURAL HEALTH CLINIC II	1. 130534			88. 01
90. 00 09000 CLI NI C	0. 197770			90.00
90. 01 09001 SENI OR CARE	0. 449439			90. 01
91. 00 09100 EMERGENCY	0. 112872			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 744726			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE	COST TO CHARGE RATIOS NET OF Provider CCN: 15-1310	Peri od: Worksheet C

From 01/01/2023 | Part II To 12/31/2023 | Date/Time Prepared: REDUCTIONS FOR MEDICALD ONLY 5/24/2024 1:32 pm Title XIX Hospi tal PPS Total Cost Capital Cost Operating Cost Operating Cost Cost Center Description Capi tal (Wkst. B, Part (Wkst. B, Part Net of Capital Reducti on Reducti on I, col. 26) II col. 26) Cost (col. 1 Amount col. 2) 2.00 5. 00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 587, 182 799, 603 3, 787, 579 50.00 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 959, 365 754, 796 4, 204, 569 54.00 0 54.00 06000 LABORATORY 4, 114, 991 3, 632, 677 60.00 60.00 482, 314 0 06600 PHYSI CAL THERAPY 2, 139, 949 66.00 2, 305, 214 165, 265 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 468, 148 58,007 410, 141 0 67.00 68.00 06800 SPEECH PATHOLOGY 156, 368 12, 532 143, 836 0 68.00 2, 295, 404 06900 ELECTROCARDI OLOGY 345, 473 69.00 1, 949, 931 Λ 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 283, 527 17, 663 265, 864 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 852, 496 177, 707 2, 674, 789 0 72.00 07300 DRUGS CHARGED TO PATIENTS 814, 420 o 73.00 9, 913, 219 9, 098, 799 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 4, 686, 795 361, 459 4, 325, 336 0 0 88.00 08801 RURAL HEALTH CLINIC II 10, 819, 750 1,079,033 9, 740, 717 0 88. 01 88. 01 0 09000 CLI NI C 300. 917 28, 876 272, 041 90.00 90 00 0 09001 SENI OR CARE 239, 485 90.01 1, 410, 058 1, 170, 573 0 90.01 91.00 09100 EMERGENCY 4, 935, 046 721, 579 4, 213, 467 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 350, 163 92.00 2, 135, 284 1, 785, 121 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 Subtotal (sum of lines 50 thru 199) 6, 408, 375 49, 815, 389 0 0 200.00 200.00 56, 223, 764 201.00 Less Observation Beds 2, 135, 284 350, 163 1, 785, 121 0 0 201.00

54, 088, 480

6, 058, 212

48, 030, 268

0 202.00

ol

202.00

Total (line 200 minus line 201)

REDUCTIONS FOR MEDICALD ONE!			To	12/31/2023	Date/Time Pro 5/24/2024 1:3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of					
	Capital and		Cost to Charge			
	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	4, 587, 182	23, 882, 993				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0.000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0	C	0.000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 959, 365	39, 352, 849				54.00
60. 00 06000 LABORATORY	4, 114, 991	32, 541, 689				60.00
66. 00 06600 PHYSI CAL THERAPY	2, 305, 214	6, 001, 676	0. 384095			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	468, 148	921, 011	0. 508298			67. 00
68. 00 06800 SPEECH PATHOLOGY	156, 368	485, 981	0. 321757			68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 295, 404	12, 052, 547	0. 190450			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	283, 527	3, 595, 136	0. 078864			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 852, 496	10, 703, 029	0. 266513			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 913, 219	38, 137, 872	0. 259931			73. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	4, 686, 795	2, 929, 947	1. 599618			88. 00
88.01 08801 RURAL HEALTH CLINIC II	10, 819, 750	9, 570, 478	1. 130534			88. 01
90. 00 09000 CLI NI C	300, 917	1, 521, 548	0. 197770			90.00
90. 01 09001 SENI OR CARE	1, 410, 058	3, 137, 373	0. 449439			90. 01
91. 00 09100 EMERGENCY	4, 935, 046	43, 722, 530	0. 112872			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 135, 284	2, 867, 209	0. 744726			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	C	0.000000			95. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	56, 223, 764	231, 423, 868	3			200.00
201.00 Less Observation Beds	2, 135, 284	C				201.00
202.00 Total (line 200 minus line 201)	54, 088, 480	231, 423, 868	3			202. 00

Heal th	Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	
			Title	: XVIII	Hospi tal	5/24/2024 1: 3 Cost	2 pm
	Cost Center Description	Capi tal	Total Charges			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						
50.00	05000 OPERATING ROOM	799, 603	23, 882, 993	0. 03348	412, 585	13, 813	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	754, 796	39, 352, 849	0. 01918	333, 653	6, 399	54.00
60.00	06000 LABORATORY	482, 314	32, 541, 689	0. 01482	732, 268	10, 853	60.00
,,	A COO DUNGS ON THE DADY	415 015	, , , , , , , , , , , , ,			0 750	,,

165, 265

58,007

12, 532

345, 473

17, 663

177, 707

814, 420

361, 459

28, 876

239, 485

721, 579

350, 163

6, 408, 375

1, 079, 033

6,001,676

485, 981 12, 052, 547

3, 595, 136

10, 703, 029

38, 137, 872

2, 929, 947

9, 570, 478

1, 521, 548

3, 137, 373

43, 722, 530

2, 867, 209

231, 423, 868

921, 011

0.027536

0.062982

0.025787

0.028664

0.004913

0.016603

0. 021355

0. 123367

0.112746

0. 018978

0.076333

0.016504

0. 122127

3, 750

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136, 203

106, 758

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2, 494

3, 106

8, 557

3, 489, 101

607, 200

144, 021 882, 297

09000 CLI NI C

09001 SENI OR CARE

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

66.00

67.00

68.00

69.00

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73.00

88.00

88. 01

90.00

90. 01

91.00

92.00

200.00

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

06700 OCCUPATIONAL THERAPY

08800 RURAL HEALTH CLINIC

08801 RURAL HEALTH CLINIC II

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS			Peri od: From 01/01/2023 To 12/31/2023		
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 SENI OR CARE	0	0		0	0	90. 01
91. 00	09100 EMERGENCY	0	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00

95.00 0 200. 00

52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0.000000 52. 53. 00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 39, 352, 849 0.000000 54. 60. 00 06000 LABORATORY 0 0 0 32, 541, 689 0.000000 66. 66. 00 06600 PHYSI CAL THERAPY 0 0 0 6, 001, 676 0.000000 66. 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 921, 011 0.000000 66. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 485, 981 0.000000 68. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12, 052, 547 0.000000 69. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 10, 703, 029 0.000000 <th></th> <th><i></i></th> <th>ARKVIEW WABASH</th> <th></th> <th></th> <th>In Lie</th> <th>eu of Form CMS-2</th> <th>2552-10</th>		<i></i>	ARKVIEW WABASH			In Lie	eu of Form CMS-2	2552-10
Title XVIII Hospital Cost Cost Center Description			RVICE OTHER PASS	S Provider CO		From 01/01/2023	Part IV	nared:
ANCILLARY SERVICE COST CENTERS						10 12/31/2023		
Medical Education Cost 1, 2, 3, and 4								
Education Cost 1, 2, 3, and Cost (sum of col s. 2, 3, and 4)		Cost Center Description						
A) Col S. 2, 3, and 4) Col S. 2, 3, and 4,				`				
ANCI LLARY SERVI CE COST CENTERS			Education Cost	, , , , , , , , , , , , , , , , , , , ,				
ANCILLARY SERVICE COST CENTERS S. 00 S.				4)		8)		
ANCILLARY SERVICE COST CENTERS					and 4)			
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05000 DELI VERY ROOM & LABOR ROOM 55. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05400 RADI OLOGY-DI AGNOSTI C 58. 00 05400 RADI OLOGY-DI AGNOSTI C 59. 00 05400 RADI OLOG			4.00	Г 00	/ 00	7.00		
50.00		ANCLLLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0.000000 D.000000 52. 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0.000000 D.000000 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 39, 352, 849 D.000000 D.000000 0.000000 D.000000 54. 60. 00 06000 LABORATORY 0 0 0 32, 541, 689 D.000000 0.000000 D.00000 66. 66. 00 06600 PHYSI CAL THERAPY 0 0 0 6, 001, 676 D.000000 D.00000 66. 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 921, 011 D.000000 D.00000 D.00000 66. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 485, 981 D.000000 D.00000 D.000000 D.00000 D.000000 D.00000 D.00000 D.00000 D.000000 D.00000 D.00000 D.00000 D.00000 D.00000 D.00000 D.00000 D.000000 D.000000 D.000000 D.000000 D.000000 D.000000 D.000000 D.000000 D.000000 D.0000000 D.000000 D.0000000 D.0	50 OO					22 002 002	0.00000	50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0.000000 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 39, 352, 849 0.000000 54. 60.00 06000 LABORATORY 0 0 0 32, 541, 689 0.000000 60. 66.00 06600 PHYSI CAL THERAPY 0 0 0 6,001, 676 0.000000 66. 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 921, 011 0.000000 66. 68.00 06800 SPEECH PATHOLOGY 0 0 0 485, 981 0.000000 68. 69.00 06900 ELECTROCARDI OLOGY 0 0 0 12, 052, 547 0.000000 69. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 3, 595, 136 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 38, 137, 872				0		0 23,002,773		
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 39, 352, 849 0.000000 54. 60. 00 06000 LABORATORY 0 0 0 32, 541, 689 0.000000 60. 66. 00 06600 PHYSI CAL THERAPY 0 0 0 60.01, 676 0.000000 66. 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 921, 011 0.000000 66. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 485, 981 0.000000 67. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12, 052, 547 0.000000 69. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 3, 595, 136 0.000000 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 38, 137, 872 0.000000 72. 73. 00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 0 2, 929, 947 0.000000 73. 88. 01 O8801 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>			0	0		0 0		
60. 00			0	0		0 39 352 849		
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 6,001,676 0.000000 66. 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 921,011 0.000000 67. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 485,981 0.000000 68. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12,052,547 0.000000 69. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 3,595,136 0.000000 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 10,703,029 0.000000 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 38,137,872 0.000000 73. 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 9,570,478 0.000000 88. 89. 01 08801 RURAL HEALTH CLINIC 0 0 0 1,521,548 0.000000 90. 90. 01 09000 SENIOR CARE 0 0 0 3,137,373 0.000000 91. 90. 00 09100 EMERGENCY 0 0 0 43,722,530 0.000000 91.			0	0			l	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 921, 011 0.000000 67. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 485, 981 0.000000 68. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12, 052, 547 0.000000 69. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 3, 595, 136 0.000000 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 10, 703, 029 0.000000 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 38, 137, 872 0.000000 73. 001741 ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 2, 929, 947 0.000000 88. 88. 01 08801 RURAL HEALTH CLINI C II 0 0 0 0, 570, 478 0.000000 88. 90. 00 09000 CLINI C 0 0 0 1, 521, 548 0.000000 90. 90. 01 09001 SENI OR CARE 0 0 0 0 3, 137, 373 0.000000 90. 91. 00 09100 EMERGENCY 0 0 0 0 43, 722, 530 0.000000 91.			0	0			l .	
68. 00			0	0			1	•
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 12, 052, 547 0.000000 69. 69. 69. 0 0 0 0 12, 052, 547 0.000000 69. 69.			0	Ö				
72. 00	69. 00	06900 ELECTROCARDI OLOGY	0	0		· ·	l	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 38, 137, 872 0.000000 73. 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 2, 929, 947 0.000000 88. 88. 01 08801 RURAL HEALTH CLINIC 0 0 0 9, 570, 478 0.000000 88. 90. 00 09000 CLINIC 0 0 0 1, 521, 548 0.000000 90. 90. 01 09001 SENIOR CARE 0 0 0 3, 137, 373 0.000000 90. 91. 00 09100 EMERGENCY 0 0 0 43, 722, 530 0.000000 91.	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 3, 595, 136	0.000000	71. 00
SERVICE COST CENTERS	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 703, 029	0.000000	72. 00
88. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 38, 137, 872	0. 000000	73. 00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 9,570,478 0.000000 88. 90. 00 09000 CLINIC 0 0 0 1,521,548 0.000000 90. 90. 01 09001 SENI OR CARE 0 0 0 3,137,373 0.000000 90. 91. 00 09100 EMERGENCY 0 0 43,722,530 0.000000 91.		OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 0 0 1,521,548 0.000000 90.	88.00	08800 RURAL HEALTH CLINIC	0	0		0 2, 929, 947	0.000000	88. 00
90. 01 09001 SENI OR CARE 0 0 3, 137, 373 0.000000 90. 91. 00 09100 EMERGENCY 0 0 0 43, 722, 530 0.000000 91.			0	0		0 9, 570, 478	0.000000	88. 01
91. 00 09100 EMERGENCY 0 0 43, 722, 530 0. 000000 91.			0	0				
			0	0			l e	1
			0	0			ł	1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 2, 867, 209 0. 000000 92. OTHER RELIMBURSABLE COST CENTERS	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 867, 209	0.000000	92. 00

92.00 95.00

200.00

231, 423, 868

	Financial Systems P TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	<u>ARKVLEW WABASH F</u> RVLCE OTHER PASS			Peri od:	u of Form CMS-2 Worksheet D	
THROUG	SH COSTS				From 01/01/2023	Part IV	
					To 12/31/2023	Date/Time Pre 5/24/2024 1:3	pared:
			Title	: XVIII	Hospi tal	Cost	Ζ μιιι
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	ocat contain book in per an	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	3 - 3	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	412, 585		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	333, 653		0	0	54.00
60.00	06000 LABORATORY	0. 000000	732, 268		0	0	60.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	136, 203		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	106, 758		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	41, 822		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	607, 200		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	78, 137		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	144, 021		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	882, 297		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	00.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
90.00	09000 CLI NI C	0. 000000	2, 494		0	0	90.00
90. 01	09001 SENI OR CARE	0. 000000	0		0	0	, , , , , ,
91.00	09100 EMERGENCY	0. 000000	3, 106		0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	8, 557		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		3, 489, 101		0	0	200.00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	<u> </u>	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/24/2024 1:3	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
	1.00		(see inst.)	(see inst.)		
ANOTHER DESIGNATION OF THE PROPERTY OF THE PRO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 192069		3, 431, 50	3 0	0	00.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000		(0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 126023		7, 715, 46		0	54.00
60. 00 06000 LABORATORY	0. 126453		5, 626, 65		0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 384095		1, 490, 66		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 508298		137, 080		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 321757		62, 37		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 190450		2, 520, 73		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 078864		454, 32		0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 266513		1, 713, 84		0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 259931	0	13, 491, 55	7 201	0	73. 00
OUTPATIENT SERVICE COST CENTERS	ı	1		1		
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
90. 00 09000 CLI NI C	0. 197770		287, 33		0	
90. 01 09001 SENI OR CARE	0. 449439		397, 81		0	
91. 00 09100 EMERGENCY	0. 112872		7, 670, 84		0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 744726	0	616, 11:	2 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	1					
95. 00 09500 AMBULANCE SERVICES	0. 000000		(O .		95. 00
200.00 Subtotal (see instructions)		0	45, 616, 31	9 405	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			(0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	l	0	45, 616, 31	9 405	0	202. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Time Prepared:

					10 12/31/2023	Date/IIme Pre 5/24/2024 1:3	
			Ti tl e	XVIII	Hospi tal	Cost	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	CILLARY SERVICE COST CENTERS	,					1
	OOO OPERATING ROOM	659, 086	0				50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
	300 ANESTHESI OLOGY	0	0)			53.00
	400 RADI OLOGY-DI AGNOSTI C	972, 326	0)			54.00
60.00 06	000 LABORATORY	711, 508	0				60.00
66.00 06	600 PHYSI CAL THERAPY	572, 558	0				66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	69, 677	0				67. 00
68. 00 06	800 SPEECH PATHOLOGY	20, 071	0				68. 00
69. 00 06	900 ELECTROCARDI OLOGY	480, 073	0)			69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 830	0)			71.00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	456, 763	0)			72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	3, 506, 874	52				73. 00
OU.	TPATIENT SERVICE COST CENTERS						1
88. 00 08	800 RURAL HEALTH CLINIC						88. 00
88. 01 08	801 RURAL HEALTH CLINIC II						88. 01
90. 00 09	0000 CLI NI C	56, 826	0)			90.00
90. 01 09	001 SENI OR CARE	178, 793	0)			90. 01
91.00 09	100 EMERGENCY	865, 824	23				91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	458, 835	O				92.00
ОТ	HER REIMBURSABLE COST CENTERS						1
95. 00 09	500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	9, 045, 044	75				200.00
201. 00	Less PBP Clinic Lab. Services-Program	o					201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	9, 045, 044	75				202. 00
	•			•			-

Health Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2023		
				Γο 12/31/2023	Date/Time Pre 5/24/2024 1:3	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
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	1, 141, 671	24, 699	1, 116, 972	4, 839	230. 83	30. 00
43. 00 NURSERY	0			0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 141, 671		1, 116, 972	4, 839		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				<u> </u>		
30. 00 ADULTS & PEDIATRICS	79	18, 236	5			30. 00
43. 00 NURSERY	0) (43.00
200.00 Total (lines 30 through 199)	79	18, 236	<u>s</u>			200. 00
	•					•

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 1:3	pared: 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		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						
50.00 05000 OPERATING ROOM	799, 603	23, 882, 993	0. 03348	0 101, 196	3, 388	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	754, 796	39, 352, 849	0. 01918	0 59, 418	1, 140	54.00
60. 00 06000 LABORATORY	482, 314	32, 541, 689	0. 01482	1 108, 540	1, 609	60.00
66. 00 06600 PHYSI CAL THERAPY	165, 265	6, 001, 676	0. 02753	6 9, 396	259	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	58, 007	921, 011	0. 06298	2 5, 603	353	67.00
68.00 06800 SPEECH PATHOLOGY	12, 532	485, 981	0. 02578	7 670	17	68. 00
69. 00 06900 ELECTROCARDI OLOGY	345, 473	12, 052, 547	0. 02866	4 58, 396	1, 674	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 663	3, 595, 136	0. 00491	3 13, 906	68	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	177, 707	10, 703, 029	0. 01660	3 57, 119	948	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	814, 420	38, 137, 872	0. 02135	5 76, 419	1, 632	73. 00
OUTPATIENT SERVICE COST CENTERS			•	•		
				_	_	l

361, 459 1, 079, 033

28, 876

239, 485

721, 579

350, 163

6, 408, 375

2, 929, 947 9, 570, 478

1, 521, 548 3, 137, 373

43, 722, 530 2, 867, 209

231, 423, 868

0. 123367

0.112746

0. 018978

0.076333

0.016504

0. 122127

0

559

99, 816

11, 667

602, 705

88.00

88. 01

90.00

90. 01

91.00

92.00

95.00

Ω

11

0

14, 171 200. 00

1, 647

<u>1, 42</u>5

08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

09000 CLI NI C

09001 SENI OR CARE

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

88.00

88. 01

90.00

90. 01

91.00

92.00

200.00

Health Financial Systems	PARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provider C		Period: From 01/01/2023 Fo 12/31/2023		pared: 2 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0) (0	0	30. 00
43. 00 04300 NURSERY	0	0) (0	0	43.00
200.00 Total (lines 30 through 199)	0	0) (0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 839	9 0.00	79	30.00
43. 00 04300 NURSERY		l 0) (0.00	0	43.00
200.00 Total (lines 30 through 199)		0	4, 839	9	79	200. 00
Cost Center Description	I npati ent			·		
· ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)						200.00
		1				

		ARKVIEW WABASH				eu of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der Co	CN: 15-1310	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/202 To 12/31/202		parad:
					10 12/31/202	5/24/2024 1: 3	pareu. 2 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Healtl	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdow	n	
		Cost	Post-Stepdown		Adj ustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0 0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0 0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
60.00	06000 LABORATORY	0	0		0	0 0	60.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0 0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0 0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0 0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	o o	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0 0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0 0	88. 01
90.00	09000 CLI NI C	0	0		0	o o	90.00
90. 01	09001 SENI OR CARE	0	0		0	o o	90. 01
91.00	09100 EMERGENCY	0	0		0	o o	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER RELABILISTADIE COCT OFFITERS	•		•		_	1

95.00 0 200. 00

Hoal th	Financial Systems P	ARKVIEW WABASH	UNC INTIGOR		In Lie	eu of Form CMS-2	2552 10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
					7.00	instructions)	
	ANOULL ARV CERVI OF COCT OFNITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	1 0			00 000 000	0.000000	
50.00	05000 OPERATING ROOM	0	0		0 23, 882, 993		
52. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	0.000000	
53. 00 54. 00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 20 252 040	0. 000000 0. 000000	
60.00	106000 LABORATORY	0	0		0 39, 352, 849 0 32, 541, 689		1
66. 00	06600 PHYSI CAL THERAPY		0		0 6, 001, 676		
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0 921, 011		
	106800 SPEECH PATHOLOGY	0	0		0 921, 011 0 485, 981		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 12, 052, 547		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 3, 595, 136		1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 10, 703, 029		1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 38, 137, 872		ł
73.00	OUTPATIENT SERVICE COST CENTERS			l	0 30, 137, 072	0.000000	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 2, 929, 947	0,000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 9, 570, 478		
90. 00	09000 CLINIC	0	0		0 1, 521, 548		
90. 01	09001 SENI OR CARE	0	o o		0 3, 137, 373		
91. 00	09100 EMERGENCY	0	Ö		0 43, 722, 530		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ō		0 2, 867, 209		
	OTHER RELIBERABLE COST OFFITERS	•		•	•		1

231, 423, 868

92.00 95.00

200.00

	Financial Systems P TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	ARKVIEW WABASH H RVICE OTHER PASS	Provi der Co		Peri od:	u of Form CMS-2 Worksheet D	
THROUG	SH COSTS				From 01/01/2023	Part IV	
					To 12/31/2023	Date/Time Pre	pared:
			Ti +1	e XIX	Hospi tal	5/24/2024 1: 3 PPS	2 pm
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	cost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .	charges	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10.00	11.00	12, 00	13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATI NG ROOM	0. 000000	101, 196		0 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	, . , . , . , 0		0 0	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	59, 418		0 0	0	1
60.00	06000 LABORATORY	0. 000000	108, 540		0 0	0	1
66.00	06600 PHYSI CAL THERAPY	0. 000000	9, 396		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 603		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	670		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	58, 396		0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	13, 906		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	57, 119		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	76, 419		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>		•			1
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
90.00	09000 CLI NI C	0. 000000	559		0 0	0	90.00
90. 01	09001 SENI OR CARE	0. 000000	0		0	0	90. 01
91.00	09100 EMERGENCY	0. 000000	99, 816		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	11, 667		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		602, 705		0 0	0	200.00

Heal th	Financial Systems Pa	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0. 192069		1	0 131, 127	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	l .	1	0	0	52. 00
	05300 ANESTHESI OLOGY	0. 000000	0	1	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 126023	0	1	0 423, 950		54. 00
60.00	06000 LABORATORY	0. 126453	l .	1	0 441, 629		60. 00
66. 00	06600 PHYSI CAL THERAPY	0. 384095			0 11, 086		66. 00
	06700 OCCUPATI ONAL THERAPY	0. 508298			0 1, 504		67. 00
	06800 SPEECH PATHOLOGY	0. 321757			0 3, 148		68. 00
	06900 ELECTROCARDI OLOGY	0. 190450	l e		0 78, 295		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 078864)	0 34, 287		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 266513)	0 69, 502		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 259931	0		0 94, 173	0	73. 00
	OUTPAȚIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88. 00
	08801 RURAL HEALTH CLINIC II						88. 01
	09000 CLI NI C	0. 197770			0 23, 685		
	09001 SENI OR CARE	0. 449439	l e		0 71, 485		
	09100 EMERGENCY	0. 112872	l e)	0 984, 317		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 744726	0		0 73, 055	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0. 000000	0)	0		95. 00
200.00			0)	0 2, 441, 243	0	200. 00
201.00					0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0	1	0 2, 441, 243	0	202. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Time Prepared:

				To 12/31/2023	Date/Time Prepared: 5/24/2024 1:32 pm
		Ti tl	e XIX	Hospi tal	PPS
	Cost	ts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subj ect To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	25, 185			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	53, 427			54. 00
60. 00 06000 LABORATORY	0	55, 845			60. 00
66. 00 06600 PHYSI CAL THERAPY	0	4, 258			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	764			67. 00
68.00 06800 SPEECH PATHOLOGY	0	1, 013			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	14, 911			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 704			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	18, 523			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 478			73. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
88.01 08801 RURAL HEALTH CLINIC II					88. 01
90. 00 09000 CLI NI C	0	4, 684			90.00
90. 01 09001 SENI OR CARE	0	32, 128			90. 01
91. 00 09100 EMERGENCY	0	111, 102			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	54, 406			92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0				95. 00
200.00 Subtotal (see instructions)	0	403, 428			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 - line 201)	0	403, 428			202. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1310	Peri od: From 01/01/2023	Worksheet D-1		
			Date/Time Prepared: 5/24/2024 1:32 pm		
	Title XVIII	Hospi tal	Cost		

TITLE XVIII Bospital Cost XMIT - ALL PROVIDER COMPONERS					5/24/2024 1: 3:	2 pm
PART - ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal		
RRATT FOR MONE COMPONENS RRATT FOR MONE COMPONENS		Cost Center Description				
MATLERT DAYS					1. 00	
1.00 Inpatient days (including private room days, excluding newborn) 4,896 1,00 Inpatient days (including private room days, excluding salangh-edal newborn days) 4,889 2,00 Inpatient days (including private room days) 1,00 Private room days (excluding saingh-edal days) 1,17 you have only private room days, 4,889 2,00 Private room days (excluding saingh-edal days) 1,17 you have only private room days, 4,889 2,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days (excluding saingh-edal days) 1,00 Private room days) 1,00 Private room days (excluding saingh-edal days excluding saingh-edal days (excluding sai		PART I - ALL PROVIDER COMPONENTS				
1. Impatient days (including private room days, excluding swing-bed and newborn days) 2. On Private room days, (excluding swing-bed and observation bed days). 3. On Private room days, (excluding swing-bed and observation bed days). 4. On 1.						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 Seel : private room days (excluding swing-bed and observation bed days). 5.01 Total swing-bed SWF type inpatient days (including private room days) through December 31 of the cost reporting period (if call endar year, enter 0 on this line). 7.00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar 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 (in line). 8.01 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (in line). 8.02 Total inpatient days (including private room days) after December 31 of the cost of the cost of the cost reporting period (in line). 8.03 Total inpatient days (including private room days) after December 31 of the cost reporting period (in line). 8.04 Total inpatient days (including private room days) after December 31 of the cost reporting period (in line). 8.05 Total swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if call endar year, ender 0 on this line). 8.06 Total swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if call endar year, ender 0 on this line). 9.01 Swing-bed SWF type inpatient days applicable to title SV or XIX only (including private room days). 9.02 Total species 31 of the cost reporting period (if call endar year, ender 0 on this line). 9.03 Total species 31 of the cost reporting period (if call endar year, ender 0 on this line). 9.04 Total species 31 of the cost reporting period (in line) on the private room days applicable to title SV or XIX only (including private room days). 9.05 Total species 31 of the cost reporting pe	1.00					
do not complete this line. 1. Ose imprivate room days (excluding swing-bed and observation bed days) 1. Ose imprivate room days (excluding private room days) after December 31 of the cost 107 for coporting period (if calendar year, enter 0 on this line) 1. Ose imprivate room days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. Ose imprivate room days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. Ose imprivate room days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. Ose imprivate room days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. Ose imprivate room days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to title XVIII only (including private room days) 1. Ose imprivate from days applicable to the Program (excluding saing-bed days) 1. Ose imprivate from the cost reporting period (if calendar year, enter 0 on this line)	2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		4, 839	2.00
	3.00	Private room days (excluding swing-bed and observation bed day	rs). If you have only pri	vate room days,	0	3.00
10tal swingbed SNF type inpatient days (including private room days) through becember 31 of the cost reporting period (if callendary sear, enter 0 on this line) 10tal swingbed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendary sear, enter 0 on this line) 10tal swingbed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendary sear, enter 0 on this line) 10tal inpatient days including private room days) after December 31 of the cost reporting period (if callendary sear, enter 0 on this line) 10tal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10tal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10tal inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10tal inpatient days applicable to title swill in private room days) 10tal inpatient days applicable to title swill in private room days) 10tal swing-bed SNF type inpatient days applicable to titles via XIX only (including private room days) 10tal swing-bed NF type inpatient days applicable to titles via XIX only (including private room days) 10tal swing-bed NF type inpatient days applicable to titles via XIX only (including private room days) 10tal nursery days (title via XIX only)		do not complete this line.				
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10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	107	5. 00
reporting period (if Calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost room days) after December 31 of the cost room days) after December 31 of the cost room days (and including private room days) after December 31 of the cost room days) applicable to this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 11.00 Swing-bed SNF type inpatient days applicable to the Vill only (including private room days) after become 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to the Vill only (including private room days) after become 31 of the cost reporting period (fir calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title SV or XX only (including private room days) 13.00 Aging-bed NF type inpatient days applicable to title SV or XX only (including private room days) 14.00 Micrograph Posember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Aging-bed NF type inpatient days applicable to titles V or XX only (including private room days) 16.00 Micrograph (swing-bed NF type inpatient days) 17.00 Micrograph (swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 18.00 Micrograph (swing-bed NF type) inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Micrograph (swing-bed NF type) inpatient days applicable to services after December 31 of the cost reporting period (line Swing-bed SNF services applicable to services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line		reporting period				
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10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if C calendar year, enter 0 on this line) 10.00 Saing-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 to XVIII only (including private room days) 11.00 Saing-bed SNF type inpatient days applicable to title to XVIII only (including private room days) after SNF type inpatient days applicable to title to XVIII only (including private room days) after SNF type inpatient days applicable to title to XVIII only (including private room days) after SNF type inpatient days applicable to title XVIII only (including private room days) after SNF type services applicable to title XVIII only (including private room days) 12.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Into Inursery days (title V or XIX only) 16.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (Including private room days) 18.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days) 18.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days) 18.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days) 18.00 NG Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including private room days) 18.00 NG Modical drate for swing	7.00		n days) through December	31 of the cost	0	7. 00
reporting period (if Calendar year, énter 0 on this line) 10.00 Sinja-bed SM Type livate room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Sinja-bed SM Type lipatient days applicable to title XVIII only (including private room days) 11.00 Sinja-bed SM Type lipatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 11.00 Sinja-bed SM Type lipatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Sinja-bed MF type lipatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed 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 SMF services applicable to services after December 31 of the cost reporting period (in period Medical rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (in period Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in period Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in period New Japan SMF) 18.00 Sinja-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X in period New Japan SMF) 18.00 Sinja-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X in period New Japan SMF) 18.00 Sinja-bed cost applicable to SMF type services after December 31 of the cost reporting period (line of X in period New Japan SMF) 18.00 Sinja-bed cost applicable to SMF type services after December 31 of						
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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) 1,407.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,576,478 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 811, 251	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,407.57 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,576,478 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				·]
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 407. 57	38. 00
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,576,478 41.00						
	41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 576, 478	41.00

COMPLIT	Financial Systems F ATION OF INPATIENT OPERATING COST		Р	rovider C	CN: 15-1310	Peri od:	eu of Form CMS- Worksheet D-1	
	THE CONTRACT OF ENTITIES CONTRACT CONTR					From 01/01/2023 To 12/31/2023		pared:
	Cost Contar Dosorintian	Total	1 -	Ti tl e Fotal	Average Per	Hospital Program Days	Cost	
	Cost Center Description				Diem (col. 1		Program Cost (col. 3 x col.	
		·			col . 2)		4)	
42 OO	NURSERY (title V & XIX only)	1.00	0	2.00	3.00	4. 00 00 0	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		<u> </u>		0. 0	00	,	42.00
43. 00	INTENSIVE CARE UNIT							43.00
44. 00	CORONARY CARE UNIT							44. 00 45. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT				•			46. 00
	OTHER SPECIAL CARE (SPECIFY)		İ					47. 00
	Cost Center Description							
48. 00	Program inpatient ancillary service cost (Wk	rst D=3 col	3 lin	e 200)			1. 00 730, 666	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Works	sheet D	-6, Part	III, line 10,	column 1)	0	1
49. 00	Total Program inpatient costs (sum of lines						2, 307, 144	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	e sorvi	cos (from	Wkst D su	m of Darte L and	0	50.00
30.00	III)	atrent routin	3CI VI	ces (110ii	WKSt. D, Sui	ii or raits r and		30.00
51. 00	Pass through costs applicable to Program in	atient ancilla	ary ser	vices (fr	om Wkst. D, s	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 exclu		el atec	l, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line	52)						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						1 0	54.00
55. 00	Target amount per discharge							55.00
55. 01	Permanent adjustment amount per discharge						0.00	
55. 02	Adjustment amount per discharge (contractor						0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operations)			amount (I	ine 56 minus	line 53)	0 0	1
58. 00	Bonus payment (see instructions)	ing cost and	tai ge t	amount (1	THE 30 III HUS	11116 33)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	0.00	59.00					
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the							
00. 00	market basket)							60.00
61. 00	Continuous improvement bonus payment (if lir						0	61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 >							
	enter zero. (see instructions)			tai got aii		5), Gtilei III 66		
62.00	Relief payment (see instructions)	ont (coo inst	suction	·c)			0 0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see msti	uction	15)				63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through De	cember	31 of the	cost reporti	ng period (See	78, 824	64.00
/E 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	to often Dece	.b.o.c. 21	of the c	act reporting	a norted (Coo	0	/ F 00
65. 00	instructions)(title XVIII only)	sts after becef	inner 31	or the c	ost reporting	g perrou (see		65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	e 64 pl	us line 6	5)(title XVII	<pre>II only); for</pre>	78, 824	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	ne costs throw	nh Dece	mher 31 c	of the cost re	enorting period	0	67.00
07.00	(line 12 x line 19)	·	•					07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after	Decemb	er 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line	67 + line	: 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILI	Y, AND	ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
71.00	Program routine service cost (line 9 x line	'	(TITIE /	U = IIIIe	2)			72.00
73. 00	Medically necessary private room cost applic	able to Progra	•		,			73.00
74.00	Total Program general inpatient routine serv	•				Don't II oolumn		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	TOULTHE SELVIO	Le CUST	s (IIOIII W	ULNSHEEL 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
	Aggregate charges to beneficiaries for exces		provi d	ler record	ls)			79.00
80. 00	Total Program routine service costs for comp	parison to the				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation (01)					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00
84. 00	Program inpatient ancillary services (see in	•	,					84. 00
85.00	Utilization review - physician compensation			05)				85. 00
oo. UU	Total Program inpatient operating costs (sun PART IV - COMPUTATION OF OBSERVATION BED PAS			(00)			1	86.00
	PART IV - CUMPUTATION OF OBSERVATION BED PAS							

1, 517 87. 00 1, 407. 57 88. 00 2, 135, 284 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

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		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023		pared: 2 pm
		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	1, 141, 671	6, 961, 861	0. 16398	9 2, 135, 284	350, 163	90.00
91.00 Nursing Program cost	0	6, 961, 861	0.00000	2, 135, 284	0	91.00
92.00 Allied health cost	0	6, 961, 861	0.00000	2, 135, 284	0	92.00
93.00 All other Medical Education	0	6, 961, 861	0. 00000	2, 135, 284	0	93. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-13	From 01/01/2023	Worksheet D-1 Date/Time Prepared:		
		12, 01, 2020	5/24/2024 1: 32 pm		
	Title XIX	Hospi tal	PPS		

		Ti +I o VI V	Hooni tal	5/24/2024 1: 32	2 pm
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	I NPATI ENT DAYS			4.044	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-le			4, 946 4, 839	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day	<i>3</i> ,	vate room days	4, 037	3. 00
0.00	do not complete this line.	, s,	vato i com dayo,	Ĭ	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 322	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	31 of the cost	107	5. 00
/ 00	reporting period		24 -6		/ 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting 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 roor	m days) through December	31 of the cost	0	7. 00
	reporting period			1	
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3°	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	79	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	o	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	ĭ	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	Y only (including private	a room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			١	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	+b	C +L+		17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	266. 32	19. 00
00.00	reporting period	CL D 1 01 C 1		0,, 00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	266. 32	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		6, 961, 861	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18) Swing-bed cost applicable to NF type services through December	r 21 of the cost reporti	ag ported (line	0	24. 00
24. 00	7 x line 19)	31 of the cost reportin	ig period (Title	١	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)			150, 610	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 811, 251	27. 00
28. 00		d and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed che	in ges)	0	
30. 00	Semi - pri vate room charges (excluding swing-bed charges)			ő	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 min		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 811, 251	37.00
	27 minus line 36)				00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 407. 57	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		111, 198 0	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39	,		111, 198	
00	1 - 1 - 3 - 2 - 2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		ı	,	50

	<u> </u>	PARKVIEW WABASH				eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1310	Peri od: From 01/01/2023 To 12/31/2023		pared:
			Ti	tle XIX	Hospi tal	PPS	2 piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Da	Average Pe ys Di em (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	C		0 0.	00 C	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit: INTENSIVE CARE UNIT	S					43. 00
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1.00	
48. 00	Program inpatient ancillary service cost (W					114, 695	
48. 01 49. 00	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines	, column 1)	0 225, 893				
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	patient routine	services (fr	om Wkst. D, su	m of Parts I and	18, 236	50.00
51. 00	III) Pass through costs applicable to Program in	patient ancilla	ry services (from Wkst. D,	sum of Parts II	14, 171	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				32, 407	52. 00
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line	uding capital re	elated, non-p	hysician anest	hetist, and	193, 486	1
	TARGET AMOUNT AND LIMIT COMPUTATION	,				1	1
54.00	Program discharges Target amount per discharge					0	54. 00 55. 00
55. 00	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor					0.00	55. 02
56.00	Target amount (line 54 x sum of lines 55, 5	1: 52)	0				
57. 00 58. 00	Difference between adjusted inpatient opera Bonus payment (see instructions)	0 0					
59. 00	Trended costs (lesser of line 53 ÷ line 54,	0.00					
60. 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54	0.00	60. 00				
61. 00	market basket) Continuous improvement bonus payment (ifli 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54	0	61. 00				
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	uctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Dece	ember 31 of t	he cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decemb	per 31 of the	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	
	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	· ·				0	
68. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)				orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69. 00
70. 00	Skilled nursing facility/other nursing faci)		70. 00
71.00	Adjusted general inpatient routine service		ine 70 ÷ lin	e 2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		n (line 14 v	line 35)			72.00
74. 00	Total Program general inpatient routine ser						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital related costs (line 9 x lin	. *					77. 00
78.00	Inpatient routine service cost (line 74 min		aroul don :	rde)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem lim	•		(.=		81. 00
82.00	Inpatient routine service cost limitation (•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	ns)				83. 00 84. 00
	Utilization review - physician compensation		ons)				85. 00
	Total Program inpatient operating costs (su	m of lines 83 th					86. 00
87 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instruction					1 517	87. 00

1, 517 87. 00 1, 407. 57 88. 00 2, 135, 284 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems PA	PARKVIEW WABASH HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2023	Worksheet D-1	
				To 12/31/2023		pared: 2 pm
	Ti tle XIX		e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 141, 671	6, 961, 861	0. 16398	9 2, 135, 284	350, 163	90.00
91.00 Nursing Program cost	0	6, 961, 861	0.00000	0 2, 135, 284	0	91.00
92.00 Allied health cost	0	6, 961, 861	0.00000	0 2, 135, 284	0	92.00
93.00 All other Medical Education	0	6, 961, 861	0. 00000	0 2, 135, 284	O	93. 00

	/IEW WABASH HOSPITAL, INC.		u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		eri od:	Worksheet D-3	
		rom 01/01/2023 o 12/31/2023	D-+- /T: D	
		o 12/31/2023	Date/Time Pre 5/24/2024 1:3	pareu: 2 nm
	Title XVIII	Hospi tal	Cost	2 piii
Cost Center Description	Ratio of Cost		Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
		3	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·			
30. 00 03000 ADULTS & PEDI ATRI CS		2, 439, 871		30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 192069	412, 585	79, 245	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 126023	333, 653	42, 048	54.00
60. 00 06000 LABORATORY	0. 126453	732, 268	92, 597	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 384095	136, 203	52, 315	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 508298	106, 758	54, 265	67.00
68.00 06800 SPEECH PATHOLOGY	0. 321757	41, 822	13, 457	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 190450	607, 200	115, 641	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 078864	78, 137	6, 162	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 266513	144, 021	38, 383	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 259931	882, 297	229, 336	73. 00
OUTPATIENT SERVICE COST CENTERS	·			
88.00 08800 RURAL HEALTH CLINIC	0.000000		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0.000000)	0	88. 01
90. 00 09000 CLI NI C	0. 197770	2, 494	493	90.00
90. 01 09001 SENI OR CARE	0. 449439	0	0	90. 01
91. 00 09100 EMERGENCY	0. 112872	3, 106	351	91.00
	1	1		l

0. 744726

8, 557

3, 489, 101

3, 489, 101

6, 373 92. 00

730, 666 200. 00

95.00

201. 00 202. 00

92. 00 | 09200 | 0BSERVATION | BEDS | (NON-DISTINCT PART | OTHER | REI MBURSABLE | COST | CENTERS | 09500 | AMBULANCE | SERVI CES |

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

200.00

201. 00 202. 00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-1310	Peri od:	Worksheet D-3	
	0 1 001 45 7040	From 01/01/2023		
	Component CCN: 15-Z310	To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Title XVIII	Swing Beds - SNF		Σ μιι
Cost Center Description	Ratio of Co		Inpatient	
	To Charges		Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
43. 00 04300 NURSERY			<u> </u>	43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 1920		0	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.0000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0.0000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1260			
60. 00 06000 LABORATORY	0. 1264			
66. 00 06600 PHYSI CAL THERAPY	0. 3840			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 5082			
68. 00 06800 SPEECH PATHOLOGY	0. 3217		•	
69. 00 06900 ELECTROCARDI OLOGY	0. 1904			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0788		34	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 2665		0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 2599	31 14, 975	3, 892	73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0.0000		0	00.00
88.01 08801 RURAL HEALTH CLINIC II	0.0000		0	88. 01
90. 00 09000 CLI NI C	0. 1977		0	90. 00
90. 01 09001 SENI OR CARE	0. 4494		0	, , , , , ,
91. 00 09100 EMERGENCY	0. 1128	72 C	0	91.00

0. 744726

66, 687

0 66, 687 92. 0095. 00

201. 00 202. 00

22, 449 200. 00

92. 00 | 09200 | 0BSERVATION | BEDS | (NON-DISTINCT PART | OTHER | REI MBURSABLE | COST | CENTERS | 09500 | AMBULANCE | SERVI CES |

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

200.00

201.00

202.00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In lie	eu of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-1310	Peri od:	Worksheet D-3	
THE THE PROPERTY OF THE STATE O	11.011.00.	From 01/01/2023		
		To 12/31/2023		
	Title XIX	Hospi tal	5/24/2024 1: 3: PPS	2 pm
Cost Center Description	Ratio of Co		Inpati ent	
cost center bescription	To Charge:		Program Costs	
	To charge.		(col. 1 x col.	
		onal goo	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS		171, 538		30.00
43. 00 04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 1920	101, 196	19, 437	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.0000	000	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0.000	000	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1260	59, 418	7, 488	54. 00
60. 00 06000 LABORATORY	0. 126	53 108, 540	13, 725	60. 00
66. 00 06600 PHYSI CAL THERAPY	0. 3840	9, 396	3, 609	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 5083	98 5, 603	2, 848	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 321			
69. 00 06900 ELECTROCARDI OLOGY	0. 190			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0788			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 266	· ·		
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 259	76, 419	19, 864	73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	1. 5990		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	1. 130		0	88. 01
90. 00 09000 CLI NI C	0. 197			90. 00
90. 01 09001 SENI OR CARE	0. 449		0	90. 01
91. 00 09100 EMERGENCY	0. 112			
02 00 00200 ORCEDVATION REDC (NON DISTINCT DADT	0.744	11 447	0 (00)	02 00

11, 667

602, 705

602, 705

8, 689 92. 00

114, 695 200. 00

95.00

201. 00 202. 00

0. 744726

92. 00 | 09200 | 0BSERVATION | BEDS | (NON-DISTINCT PART | OTHER | REI MBURSABLE | COST | CENTERS | 09500 | AMBULANCE | SERVI CES |

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

200.00

201.00

202.00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/24/2024 1:32 pm

PART P. INFIDEM_AND CHER HEATH SERVICES 1.00				10 12/31/2023	5/24/2024 1: 3	
Mart B With Call Abb Office International Company 1.00 Notice and other services (see instructions) 0.00 0.			Title XVIII	Hospi tal		
Mart B With Call Abb Office International Company 1.00 Notice and other services (see instructions) 0.00 0.		· · · · · · · · · · · · · · · · · · ·				
Medical and other services (see instructions)					1. 00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES				
0.00 OPES or EPIL preparent (see instructions) 0.3.00 0.4.01 OUT iter record i lation amount (see instructions) 0.4.01 0.4.01 0.01 0.00	1.00	Medical and other services (see instructions)			9, 045, 119	1.00
Quiller payment (see instructions)		· ·	ti ons)		1	
Action Continue	3.00	OPPS or REH payments			0	3. 00
Enter the hospit bil specific payment to cost ratio (see Instructions)					0	
Line 2 times line 5 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·			-	1
	5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
Transit foral corridor payment (see instructions)	6.00	Line 2 times line 5			0	6. 00
Ancil Tlary service other pass through costs including REH direct graduate medical education costs from 0 0, 00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
Misch D, PPL IV, col. 13, line 200 10.00		, , , , , , , , , , , , , , , , , , , ,			-	
10.00 Grgan acquisit ions 0 10.00 0 2,045,119 11.00 Total cost (sum of Lines 1 and 10) (see instructions) 9,455,119 11.00 11.00 15.00 15.00 15.00 12.00 12.00 12.00 13.00 14.00 15.00 14.00 15.0	9.00		ct graduate medical educa	ation costs from	0	9. 00
1.00 Total cost (sum of lines 1 and 10) (see instructions) 9,045,119 10.00						
COMPUTATION OF LESSER OF COST OR CHARGES					0	1
Reasonable charges	11. 00				9, 045, 119	11. 00
12.00 Ancil lary service charges 0 12.00 13.00 0rgan acquistion charges (from West D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 15.01 10						1
13.00 Organ acquisition charges (from Wiskst. D-4, Pt. III., col. 4, line 69)						1
14.00						
Countries Coun			ne 69)		1	
15.00 Aggregate amount actually collected from patients 16.00	14. 00				0	14. 00
16.00 Anicunits that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 Natio of Tine 15 to Tine 16 (not to exceed 1.000000) 0.000000 17.00 18.0						
had such payment been made in accordance with 42 CFR \$413.13(e)*					1	
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 19.00 19.00 17.00 18.00 19.00 17.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00	16. 00			n a chargebasis	0	16. 00
18.00	47.00		e)			47.00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19. 00						1
instructions				44) (1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 Instructions) 9, 135, 570 21.00	19.00		y if line 18 exceeds li	ne 11) (see	0	19.00
Instructions	20.00	,	: € : 44	10) (20.00
21.00 Lesser of cost or charges (see instructions) 9,135,770 21.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0,23.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0,23.00 24.00 Cost of physicians' services in a teaching hospital (see instructions) 0,23.00 24.00 Cost of physicians' services in a teaching hospital (see instructions) 0,23.00 24.00 Cost of physicians' services in a teaching hospital (see instructions) 0,23.00 25.00 Cowputation of REIMBURSEMENT SETTLEMENT 0,000 0,000 26.00 Deductibles and Colinsurance amounts (for CAH, see instructions) 7,963,290 26.00 26.00 Deductibles and Colinsurance amounts relating to amount on line 24 (for CAH, see instructions) 7,963,290 26.00 26.00 Deductibles and Colinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1,081,395 27.00 27.00 Subtotal (films 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see 1,081,395 27.00 28.00 Deductibles and Colinsurance amounts (from Wkst. E-4, line 50) 2,000 28.00 Defuct graduate medical education payments (from Wkst. E-4, line 50) 2,000 28.00 Defuct graduate medical education payments (from Wkst. E-4, line 36) 2,000 29.00 ESR6 direct graduate medical education costs (from Wkst. E-4, line 36) 2,000 29.00 Subtotal (line 30 minus line 31) 1,081,395 30.00 29.00 Subtotal (line 30 minus line 31) 1,080,300 30.00 29.00 Subtotal (line 30 minus line 31) 1,080,300 30.00 29.00 Composite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 29.00 Omposite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 29.00 Omposite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 29.00 Omposite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 29.00 Omposite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 29.00 Omposite rate ESR0 (from Wkst. I-5, line 11) 0 39	20.00		y IT Time II exceeds III	ne 18) (See	ĺ	20.00
22.00 Interns and residents (see instructions) 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.22.00 0.00	21 00				0 125 570	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00		9 \				
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		· · · · · · · · · · · · · · · · · · ·	suctions)		1	1
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 90,885 25.00			uctions)		1	1
25.00 Deductible sand coinsurance amounts (for CAH, see instructions) 90,885 25.00 26.00 Deductible sand Coinsurance amounts of line 24 (for CAH, see instructions) 7,963,200 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1,081,395 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 28.00 29.00 28.00 29.00 28.00 29.00	24.00				0	24.00
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 7,963,290 26.00	25 00		-)		00.005	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1,081,395 27.00 instructions) 0 28.00		1	•	uctions)		1
Instructions		l	•			1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28. 00 28. 50 28. 50 28. 50 28. 50 28. 50 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00	27.00		of us the sum of fittes 22	and 23] (See	1,001,393	27.00
28.50 REH Facility payment amount (see instructions) 0.9 0.0 0.9 0.0 0.0	28 00		ne 50)		0	28 00
29.00 SSRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0			110 00)		Ĭ	1
30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 1,081,395 30.00 Primary payer payments 1,081,395 31.00 31.00 32.00 Subtotal (line 30 minus line 31) 1,080,306 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 775,313 34.00 33.00 Composite rate ESRD (from West. I -5, line 11) 0 33.00 35.00 Allowable bad debts (see instructions) 775,313 34.00 35.00 Allowable bad debts (see instructions) 503,393 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 341,981 36.00 37.00 38.00 MSP-LCC recordiciation amount from PS&R 1,584,259 37.00 39.					1	1
31.00 Subtotal (line 30 minus line 31) 1.089 31.00 31.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (From Wkst. I -5, line 11) 0 33.00 33.00 33.00 33.00 34.00 Allowable bad debts (see instructions) 775, 313 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 341, 981 36.00 37.00 38.0					1	1
32.00						1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 775, 313 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 503, 953 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 341, 981 36.00 37.00 Subtotal (see instructions) 1, 584, 259 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCD reconciliation amount from PS&R 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.75 39.79 Pomonstration payment adjustment amount before sequestration 0 39.97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 1,584,259 40.00 40.02 40.03 Sequestration adjustment amount after sequestration 0 40.02 40.03 40.00 40						
33.00 Composite rate ESRD (from Wkst I -5, line 11)	32.00		`FS)		1,000,000	32.00
34.00	33 00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33 00
35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 341, 981 36.00 37.00 Subtotal (see instructions) 1,584, 259 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 Ploneer ACO demonstration payment adjustment (see instructions) 39.50 97.						1
36.00						1
37.00 Subtotal (see instructions) 1,584,259 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 39.00 39.50 97.50			ructions)			1
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 50 39. 50 39. 75 39. 75 39. 75 39. 77 59. 77 Demonstration payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Sequestration adjustment (see instructions) 1,584, 259 40. 00 40. 01 40		1	4011 0113)			1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.97 39.98 39.99 39.99 39.99 39.99 39.99 39.90						1
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 N95 respirator payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 31,685 40.01 40.02 Demonstration adjustment (see instructions) 31,685 40.01 40.02 40.03 Sequestration adjustment amount after sequestration 40.02 40.03 Sequestration adjustment amount after sequestration 40.02 40.03 Interim payments 41.01 1 Interim payments 41.01 42.01 42.01 42.01 43.00 Balance due provider/program (see instructions) 42.01 43.00 Balance due provider/program (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						1
39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 1, 584, 259 40. 00 40. 01 Demonstration adjustment (see instructions) 31, 685 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment (see instructions) 31, 685 40. 01 40. 02 Sequestration adjustment amount after sequestration 40. 02 41. 00 Interim payments 1, 462, 395 41. 00 41. 01 Interim payments-PARHM 41. 00 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 90. 179 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 45. 01 44. 00 Sil15. 2			5)		1	1
39. 97 39. 98 39. 88 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 98 39. 99 39. 90 30 39. 90 30 39. 90 30 39. 90 30 39. 90 30 30 30 30 30 30 30 30 30 30 30 30 30			-,		0	1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 1, 584, 259 40. 00 40. 01 Sequestration adjustment (see instructions) 31, 685 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 1, 462, 395 41. 00 41. 01 Interim payments-PARHM 1, 462, 395 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 01 Bal ance due provider/program (see instructions) 90, 179 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Oniginal outlier amount (see instructions) 0 90. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 90. 00 The rate used to calculate the Time Value of Money <td></td> <td>1</td> <td></td> <td></td> <td>1</td> <td></td>		1			1	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 5 5 5 5 5 5 5 5 5			red devices (see instruc	tions)	1	1
40.00 Subtotal (see instructions) 1,584,259 40.00 40.01 Sequestration adjustment (see instructions) 31,685 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 1,462,395 41.00 41.01 Interim payments-PARHM 1,462,395 41.00 42.01 Tentative settlement-PARHM (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 90,179 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 5115. 2 TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00		· ·	Sed devices (See Histiac	LI UIIS)	1	1
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 5 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 1 Interim payments 1 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 90.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.01 Adv. 00					1	1
40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 1,462,395 41.00 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 For instructions 0 90.00 90.00 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 92.00		· · · · · · · · · · · · · · · · · · ·				1
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 1nterim payments 42. 00 1nterim payments 42. 00 42. 00 42. 00 42. 00 42. 00 43. 00 43. 00 8al ance due provider/program (see instructions) 43. 00 8al ance due provider/program-PARHM (see instructions) 43. 01 44. 00						1
41.00		, , , , , , , , , , , , , , , , , , , ,			1	1
41.01 Interim payments-PARHM					1 440 205	1
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 0 42.00 42.01 42.01 42.01 43.00 42.01 43.00 90.179 43.00 90.01 91.00 91.00 92.00		' '			1, 462, 395	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 0riginal outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 94.00 The rate used to calculate the Time Value of Money 95.00 The rate used to calculate the Time Value of Money 96.01 The rate used to calculate the Time Value of Money 97.01 The rate used to calculate the Time Value of Money 98.02 The rate used to calculate the Time Value of Money 99.03 The rate used to calculate the Time Value of Money					_	1
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\fra		1			1	1
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 43.01 44.00 45.01 46.00 47.00 47.00 49.00 49.00 49.00 49.00 90.0		,			00 170	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f					90, 179	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 voltlier reconciliation adjustment amount (see instructions)			acc with CMC Dult 15 0	chantar 1	_	1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 70.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44.00	,	ICE WITH CMS PUD. 15-2, (chapter I,	1	44.00
90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 91.00 92.00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		, ,			1	
		,			1	1
75.55 1.1.10 13.10 01 110110 (350 111311 0511 015)						1
		1 12. 23 01				

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In L	ieu of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN:	15-1310 Peri od:	Worksheet E	
		From 01/01/202		
		To 12/31/202		pared:
			5/24/2024 1:3	2 pm
	Title X\	/III Hospital	Cost	
			1. 00	
94.00 Total (sum of lines 91 and 93)			C	94. 00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			C	200. 00

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

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.						5/24/2024 1: 32	2 pm
1.00			Title	XVIII	Hospi tal		
Total interim payments paid to provider 1.00 2.00 3.00 4.00			Inpatien	t Part A	Par	t B	
Total interim payments paid to provider 1.00 2.00 3.00 4.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
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.						4.00	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero 1.00	1.00	Total interim payments paid to provider		1, 861, 92	2	1, 216, 995	1. 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 3.02 3.03 3.03 3.04 3.05 Provider to Program 3.51 3.52 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines appropriate) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) (transfer to Wkst. E-3, line an		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,					2. 00
3.02 3.03 3.03 3.04 3.05 3.05 3.05 3.06 3.06 3.07	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)					3. 00
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 3.50.3 98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR TO RENATIVE TO PROGRAM 5.00 Froylet to Program 5.00 6.01 5.50 7.50 8.50 9.02 9.03 9.04 9.04 9.04 9.04 9.04 9.04 9.04 9.04 9.04 9.04 9.04 9.05 9.06 9.06 9.07 9	3.01	ADJUSTMENTS TO PROVIDER	08/03/2023	181, 80	0 08/03/2023	245, 400	3. 01
3.04	3.02				o	0	3. 02
3.05	3.03				o	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.55	3.04				o	0	3.04
ADJUSTMENTS TO PROGRAM 0	3.05				0	0	3.05
3.51 3.52 3.53 0		Provider to Program					
3.52 3.53 3.54 3.99 3.52 3.53 3.99 3.50 3.99 3.50 3.99 3.50 3.99 3.50		ADJUSTMENTS TO PROGRAM					3. 50
3.53 3.54 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					-	1 - 1	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 181,800 245,400 3.99 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 1, 2, and 3.99) 2.043,722 1.462,395 4.00 7 total interim payments (sum of lines 2.01 interim payments are propried to program to provider a zero. (1) 7 total interim payments (sum of lines 5.01-5.49 minus sum of lines 2.00 2.						1	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.99 3.50-3.98) 3.99 3.50-3.98) 4.00 1.462,395 4.00 3.50-3.98) 4.00 1.462,395 4.00 3.50-3.98) 4.00 1.462,395 4.00						1	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					0	0	3. 54
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99			181, 80	0	245, 400	3. 99
TO BE COMPLÉTED BY CONTRACTOR S. 00	4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 043, 72	2	1, 462, 395	4. 00
5.00							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00	list senarately each tentative settlement navment after					5 00
Program to Provider	3.00	desk review. Also show date of each payment. If none,					3.00
5. 02 0		Program to Provider					
Solution Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement amount (balance due) based on the did are program liability (see instructions) Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement TO PROGRAM Settlement TO PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement Settlement TO PROGRAM Settlement	5. 01	TENTATI VE TO PROVI DER					5. 01
Provider to Program	5.02				0	0	5. 02
S. 50 TENTATI VE TO PROGRAM 0 0 5. 50	5.03				0	0	5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 5.51 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 0 5.52 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 5.52 0 0 0 0 0 0 5.52 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00					-		
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00					-	- 1	5. 52
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99				0	0	5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 00						6. 00
7.00 Total Medicare program liability (see instructions) 1,872,016 1,552,574 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 01	SETTLEMENT TO PROVIDER			o	90, 179	6. 01
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM		171, 70	6	0	6. 02
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program liability (see instructions)		1, 872, 01	6	1, 552, 574	7. 00
0 1.00 2.00					Contractor	NPR Date	
8.00 Name of Contractor 8.00			()	1. 00		
	8.00	Name of Contractor					8. 00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1310 Period: From 01/01/2023 Part I Date/Time Prepared: 5/24/2024 1:32 pm

Title XVIII Swing Beds - SNF Cost
Inpatient Part A Part B

mm/dd/vvvv Amount mm/dd/vvvv Amount

Inpatient Part A Part B			Title	XVIII Sv	ving Beds - SNF	Cost	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 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 "MONE" or enter a zero 3.00			Inpatien	t Part A	Par	rt B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 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 "MONE" or enter a zero 3.00							
Total interim payments paid to provider 100,369 0 1.00 2.			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either subtricted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NOME" or enter a zero 2,00			1.00	2. 00	3. 00	4. 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 Submitted to the contractive 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 O	1.00	Total interim payments paid to provider		100, 369		0	1. 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 Ust 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) 1.00 1.	2.00			0		0	2.00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							
write "NONE" or enter a zero 1.00 List separately geach 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 3.01 ADJUSTMENTS TO PROVIDER 3.02 0 0 0 3.02 3.03 0 0 0 3.03 3.04 0 0 0 0 3.03 3.05 Provider to Program 3.150 ADJUSTMENTS TO PROGRAM 3.50 0 0 0 3.50 Provider to Program 4.51 0 0 0 0 3.50 5.51 0 0 0 0 3.50 3.53 0 0 0 0 3.50 3.54 0 0 0 0 3.50 3.55 0 0 0 0 3.52 3.55 0 0 0 0 3.52 3.56 0 0 0 0 3.52 3.57 0 0 0 0 3.52 3.58 0 0 0 0 3.52 3.59 0 0 0 0 3.54 3.50 0 0 0 0 3.54 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 0 3.55 3.50 0 0 0 0 0 3.55 3.50 0 0 0 0 0 0 3.55 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interin mate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
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)	3 00						3 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER			L				
3.02 3.03 3.04 0 0 3.03 3.04 3.05	0.04						0.04
3.03 3.04 3.05 3.04 3.05 3.04 3.05 3.04 3.05		ADJUSTMENTS TO PROVIDER					
3.04 0 0 0 3.04 3.05 3.04 3.05 3.06 3.							
Contractor Con				0		-	
Provider to Program	3.04						3. 04
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50 3. 51 3. 52 0 0 0 3. 51 3. 52 3. 53 0 0 0 0 3. 53 3. 54 0 0 0 0 3. 50 3. 50 3. 50 3. 50 3. 50 3. 98 0 0 0 3. 53 3. 50 3. 98 0 0 0 3. 54 3. 90 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 100, 369 0 4. 00 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 100, 369 0 4. 00 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. 01 TENTATIVE TO PROVIDER 0 0 5. 01 5. 02 5. 03 0 0 0 5. 50 5. 50 TENTATIVE TO PROGRAM 0 0 5. 55 5. 50 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 55 - 5. 99) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETLLEMENT TO PROGRAM 130 0 6. 01 6. 02 SETILLEMENT TO PROGRAM 130 0 6. 02 7. 00 Total Medicare program liability (see instructions) 0 1. 00 2. 00	3.05			0		0	3. 05
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 0 0 0 3.59 0 0 0 0 0 0 0 0 0		Provider to Program					
3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.99	3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.53 3.54 3.54 3.59 3.50-3.98 0 0 0 3.53 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 0 0 0 0 0 0 0 0 0	3.51			0		0	3. 51
3.53 3.54 3.54 3.59 3.50-3.98 0 0 0 3.53 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 3.59 0 0 0 0 0 0 0 0 0	3. 52			0		0	3, 52
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 100,369 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) 100,369 0 4.00		Subtotal (sum of lines 2.01.2.40 minus sum of lines					
100, 369 0 4.00 100, 369 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 100, 369 0 4.00	3. 77			U		0	3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			100 260			4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			100, 309		0	4.00
TO BE COMPLÉTED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
Solition							
Description		TENTATI VE TO PROVI DER					
Provider to Program	5.02					0	5. 02
TENTATIVE TO PROGRAM 0	5.03			0		0	5. 03
TENTATIVE TO PROGRAM 0		Provider to Program					
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52	5.50			0		0	5. 50
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) 0 0 6.00 6. 01 SETTLEMENT TO PROVIDER 0 0 0 6.01 6. 02 SETTLEMENT TO PROGRAM 130 0 6.02 7. 00 Total Medicare program liability (see instructions) 100, 239 Contractor NPR Date (Mo/Day/Yr) Number Number (Mo/Day/Yr)	5. 51			0		0	5. 51
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	5. 52			0		0	5. 52
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		Subtotal (sum of lines 5 01-5 49 minus sum of lines		0		0	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0. , ,			Ĭ			0. , ,
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 130 0 6.02 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			_			6.01
7.00 Total Medicare program liability (see instructions) 100, 239 0 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				_		_	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00						-	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	lotal Medicare program Hability (see instructions)		100, 239			7.00
0 1.00 2.00							
8.00 Name or Contractor 8.00			(J	1.00	2.00	
	8.00	Name or Contractor				1	8.00

Heal th	Financial Systems PARKVII	EW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1310 Period: From 01/01/2023 To 12/31/2023 From 12/31/2023 Fro				pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST	T REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND	CALCULATI ON			
1.00	Total hospital discharges as defined in AARA §410.	2 from Wkst. S-3, Pt. I col. 15 line	14		1.00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.	line 2			3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8	line 200			5. 00
6.00	Total hospital charity care charges from Wkst. S-	10, col. 3 line 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the p line 168 $$	urchase of certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see ins	tructions)			8. 00
9.00	Sequestration adjustment amount (see instructions)			9. 00
10.00	Calculation of the HIT incentive payment after se	questration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				Ī
30.00	Initial/interim HIT payment adjustment (see instr	uctions)			30.00
	Other Adjustment (specify)	•			31.00
	Balance due provider (line 8 (or line 10) minus L	ine 30 and line 31) (see instruction	s)		32 00

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

30. 00 31. 00 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		Worksheet E-2
			From 01/01/2023	
		Component CCN, 1E 7210	To 12/21/2022	Data/Tima Dranarad

		Component CCN: 15-Z310	To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
		Title XVIII	Swing Beds - SNF		Ζ μιιι
			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)		79, 612	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		22, 673	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin	ig-bed pass-through, see			
0.01	instructions)				0.04
3. 01	Nursing and allied health payment-PARHM (see instructions)			0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teachi instructions)	ng program (see		0.00	4. 00
5.00	Program days		56	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	istructions)	30	0	6. 00
7. 00	Utilization review - physician compensation - SNF optional met	hod only	0	Ü	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		102, 285	0	8. 00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		102, 285	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		102, 285	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13. 00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15.00	Subtotal (see instructions)		102, 285	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	O	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions		0		16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstradjustment (see instructions)	ation) payment	0		16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	Ö	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		o o	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19.00	Total (see instructions)	,	102, 285	0	19. 00
19. 01	Sequestration adjustment (see instructions)		2, 046	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		100, 369	0	20. 00
20. 01	Interim payments-PARHM				20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)		400		21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	!, 19.25, 20, and 21)	-130	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	and with CMC Dub. 15 2	0	0	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordar chapter 1, §115.2	ice with CMS Pub. 15-2,	U	0	23. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, line	2		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	61. 1. 6.11			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	Tirst year of the currer	it 5-year demonst	ration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mas lina 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207 00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2				208. 00
200.00	and 3)	., cor. 1, sum of fines			200.00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1310	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/24/2024 1:32 pm

				5/24/2024 1: 32	2 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 307, 144	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ıs)		0	2. 00
3.00	Organ acquisition			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			2, 307, 144	4. 00
5. 00	Primary payer payments			2,007,111	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 330, 215	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 000, 210	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10.00
10.00	9			U	10.00
11 00	Customary charges	umant for condess on	a abarra basis	0	11 00
11. 00	Aggregate amount actually collected from patients liable for pa			- 1	
12. 00	Amounts that would have been realized from patients liable for	payment for services or	i a charge basis	0	12. 00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	12 00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)		() (0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds lin	ne 6) (see	0	15. 00
44 00	instructions)	. 6 1	44) (4 / 00
16. 00	Excess of reasonable cost over customary charges (complete only	/ IT line 6 exceeds line	e 14) (see	0	16. 00
47.00	instructions)				47.00
17. 00	Cost of physicians' services in a teaching hospital (see instru	icti ons)		0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				40.00
	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	
	Cost of covered services (sum of lines 6, 17 and 18)			2, 330, 215	
	Deductibles (exclude professional component)			446, 400	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 883, 815	
	Coi nsurance			1, 600	
24. 00	Subtotal (line 22 minus line 23)			1, 882, 215	
25. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		43, 084	
	Adjusted reimbursable bad debts (see instructions)			28, 005	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		1, 484	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 910, 220	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. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 910, 220	30.00
30. 01	Sequestration adjustment (see instructions)			38, 204	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			2, 043, 722	31. 00
	Interim payments-PARHM				31. 01
	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)			Ĭ	32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02,	31. and 32)		-171, 706	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, min		and 32.01)	, 700	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance			0	34. 00
00	\$115. 2			Ĭ	55
	1 9 *		!		

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

Provider CCN: 15-1310

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			'	0 12/31/2023	5/24/2024 1: 3	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		_	_	_	
1.00	Cash on hand in banks	1, 350		_	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		_	0	2. 00 3. 00
4. 00	Accounts receivable	21, 819, 747	1	0	0	4.00
5. 00	Other recei vable	0	o	Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-12, 369, 999	o c	0	0	6. 00
7.00	Inventory	1, 063, 938		0	0	7. 00
8.00	Prepaid expenses	44, 056		0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	17 022 142) C	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	-17, 032, 163 -6, 473, 071				11.00
11.00	FIXED ASSETS	-0, 473, 071		,	0	11.00
12. 00	Land	860, 257	' C	0	0	12.00
13.00	Land improvements	1, 897, 632	2 C	0	0	13.00
14. 00	Accumul ated depreciation	-1, 136, 791	1	0	0	14. 00
15. 00	Bui I di ngs	31, 712, 262	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-8, 048, 731		_	0	16. 00 17. 00
18. 00	Accumul ated depreciation	1 0		_	0	18.00
19. 00	Fi xed equipment	2, 207, 154			Ö	19.00
20. 00	Accumul ated depreciation	-815, 166	•	0	0	20.00
21. 00	Automobiles and trucks	18, 500) c	0	0	21.00
22. 00	Accumul ated depreciation	-18, 500	•		0	22. 00
23. 00	Major movable equipment	13, 971, 338	1	0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-10, 048, 278		0	0	24. 00 25. 00
26. 00	Accumulated depreciation	0			0	26.00
27. 00	HIT designated Assets	Ö		_	0	27. 00
28. 00	Accumul ated depreciation	0) c	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)	30, 599, 677	' <u> </u>	0	0	30.00
21 00	OTHER ASSETS	0	J 0	0	0	21 00
31. 00 32. 00	Investments Deposits on Leases	0			0	31. 00 32. 00
33. 00	Due from owners/officers	0		_	0	33. 00
34. 00	Other assets	0			0	34. 00
35.00	Total other assets (sum of lines 31-34)	0) c	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	24, 126, 606	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	4 440 550		1	_	
37. 00 38. 00	Accounts payable	1, 413, 558 677, 798	1		0	37. 00 38. 00
39. 00	Salaries, wages, and fees payable Payroll taxes payable	077,790 		9	0	39.00
40. 00	Notes and Loans payable (short term)	Ö		Ö	0	40.00
41.00	Deferred income	0	o c	0	0	41.00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	7, 698, 664		_	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	9, 790, 020) C	0	0	45. 00
46. 00	Mortgage payable	0	ol c	0	0	46. 00
47. 00	Notes payable	Ö		_		47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	19, 523, 297		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	19, 523, 297			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	29, 313, 317	' <u> </u> C	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	-5, 186, 711				52. 00
53. 00	Specific purpose fund	3, 100, 711)		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-5, 186, 711		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	24, 126, 606		0	0	60.00
	59)					
				•		

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 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period -9, 023, 672 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 3, 344, 950 2.00 3.00 Total (sum of line 1 and line 2) -5, 678, 722 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 5.00 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 0 0 8.00 0 9.00 ADJUSTMENT 492, 011 9.00 10.00 Total additions (sum of line 4-9) 492, 011 10.00 Subtotal (line 3 plus line 10) 11.00 -5, 186, 711 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 0000 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 -5, 186, 711 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 9.00 ADJUSTMENT 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00

0

0

15.00

16.00

17.00

18.00

19.00

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

 Heal th Financial Systems
 PAR

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

			To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Cost Center Description	I npati ent	Outpati ent	Total	Z piii
	3331 3311131 23331 Pt 1 311	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	7, 833, 59	8	7, 833, 598	1. 00
2.00	SUBPROVI DER - I PF	1,555,51		.,,	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7. 00	SKILLED NURSING FACILITY			Ü	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)	7, 833, 59	8	7, 833, 598	10.00
10.00	Intensive Care Type Inpatient Hospital Services	1 7,000,07	ا	1,000,070	10.00
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 line	s	0	0	16. 00
10.00	11-15)	3		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 833, 59	8	7, 833, 598	17. 00
18. 00	Ancillary services	13, 773, 81		167, 475, 733	18. 00
19. 00	Outpati ent servi ces	838, 95		51, 517, 410	19.00
20. 00	RURAL HEALTH CLINIC	i '	0 2, 929, 947	2, 929, 947	20. 00
20. 01	RURAL HEALTH CLINIC II	I	9, 570, 478	9, 570, 478	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	1	n 7, 370, 470	7, 370, 470	21. 00
22. 00	HOME HEALTH AGENCY			O	22. 00
23. 00	AMBULANCE SERVICES			0	23. 00
24. 00	CMHC			O	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26.00
27. 00	Other Patient Service Revenue		0 137, 168	137, 168	27. 00
28. 00	Total patient service Revenues Total patient revenues (sum of lines 17-27)(transfer column 3 to W	kst. 22, 446, 37		239, 464, 334	28. 00
20.00	G-3, line 1)	22, 440, 37	217,017,702	237, 404, 334	20.00
	PART II - OPERATING EXPENSES	I			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		64, 684, 235		29. 00
30.00	NONALLOWABLE HOME OFFICE INTEREST	443, 57			30.00
31. 00	NONALEONABLE HOME OFFICE INTEREST		0		31. 00
32. 00			0		32.00
33. 00		I			33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		443, 577		36.00
37. 00	DEDUCT (SPECIFY)		0 443, 377		37. 00
38. 00	DEDUCT (SPECIFT)		0		38.00
39. 00			0		39.00
40. 00			0		40.00
40.00					40.00
	Total deductions (sum of lines 27 41)				41.00
42.00	Total deductions (sum of lines 37-41)	ansfor	45 127 012		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tratto Wkst. G-3, line 4)	alistel	65, 127, 812		43.00
	LU WKSL. U-3, 1110 4)	I	1		

Heal th	Financial Systems PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1310	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		239, 464, 334	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	,		171, 671, 630	
3.00	Net patient revenues (line 1 minus line 2)			67, 792, 704	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		65, 127, 812	
5.00	Net income from service to patients (line 3 minus line 4)	,		2, 664, 892	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			1, 063	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			246, 671	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		89, 561	16.00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			5, 477	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			29, 062	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER (SPECIFY)			0	24. 00
24. 01	Mi sc Revenue			-3, 073	24. 01
24. 02	Transfer from Foundation			314, 714	24. 02
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25 00	Total other income (sum of lines 6-24)			683 475	25 00

683, 475 25. 00 3, 348, 367 26. 00 3, 417 27. 00

3, 417 28. 00 3, 344, 950 29. 00

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 LOSS ON DISPOSAL OF ASSETS

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)

Heal th	Financial Systems PA	ARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1310	Peri od:	Worksheet M-1	
					From 01/01/2023		
			Component	CCN: 15-8541	To 12/31/2023	Date/Time Pre	
					DUC I	5/24/2024 1: 3	2 pm
		10	011 0 1	T 1 1 (1	RHC I	D 1 161 1	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
		1.00	2.00	2.00	4.00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2. 00	3.00	4. 00	5.00	
1.00	Physician	561, 339	115, 678	677, 0	17	677, 017	1.00
2.00		301, 339	113,070	077,0	17	0//,01/	2.00
	Physician Assistant	202 040	42 021	245 0	91 0	-	3.00
3.00	Nurse Practitioner	203, 960	42, 031	245, 9	71	245, 991	
4.00	Visiting Nurse	414 050	85, 925	F00.00	0	0	4. 00 5. 00
5.00	Other Nurse	416, 959	85, 925	502, 8	34 0	502, 884	
6.00	Clinical Psychologist	0	Ü	1	0	0	6.00
7.00	Clinical Social Worker	U	Ü	1	0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0	1	0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	244, 419	50, 369			294, 788	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	1, 426, 677	294, 003	1, 720, 6	30 0	1, 720, 680	10.00
11. 00	Physician Services Under Agreement	0	0	1	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0	1	0 0	0	12. 00
13.00	Other Costs Under Agreement	0	0)	0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0)	0	0	14. 00
15. 00	Medical Supplies	0	188, 811			188, 811	15. 00
16. 00	Transportation (Health Care Staff)	0	2, 268	2, 20	68 0	2, 268	
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	17. 00
18. 00	Professional Liability Insurance	0	0	1	0	0	18. 00
19.00	Other Health Care Costs	0	0)	0 0	0	19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	191, 079	191, 0	79 0	191, 079	21. 00
22.00	Total Cost of Health Care Services (sum of	1, 426, 677	485, 082	1, 911, 7!	59 0	1, 911, 759	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0)	0	0	23. 00
24.00	Dental	0	0)	0	0	24. 00
25. 00	Optometry	0	0)	0	0	25. 00
25. 01	Tel eheal th	7, 373	1, 519	8, 89	92 0	8, 892	25. 01
25. 02	Chronic Care Management	0	0	1	0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	7, 373	1, 519	8, 89	92 0	8, 892	28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	155, 218	155, 2°	18 0	155, 218	29. 00
30.00	Administrative Costs	69, 313	532, 434	601, 7	47 0	601, 747	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	69, 313	687, 652	756, 90	55 0	756, 965	31.00
	30)			1			
32. 00	Total facility costs (sum of lines 22, 28	1, 503, 363	1, 174, 253	2, 677, 6	16 0	2, 677, 616	32. 00
	and 31)			1			

Component CCN: 15-8541 12/31/2023 To Date/Time Prepared: 5/24/2024 1:32 pm RHC I Net Expenses Adjustments for Allocation (col. 5 + col. 6) 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 1.00 00 677, 017 1.00 Physi ci an 2.00 Physician Assistant 2 00 0 3.00 Nurse Practitioner 245, 991 3.00 4.00 Visiting Nurse 0 0 4.00 Other Nurse 5.00 502, 884 5.00 6.00 Clinical Psychologist 6.00 7.00 Clinical Social Worker 0 7.00 7.10 Marriage and Family Therapist 7. 10 Mental Health Counselor 7.11 7.11 8.00 Laboratory Techni ci an 0 8.00 9.00 Other Facility Health Care Staff Costs 0000000000 294, 788 9.00 Subtotal (sum of lines 1 through 9) 1, 720, 680 10.00 10.00 Physician Services Under Agreement 11.00 11.00 12.00 Physician Supervision Under Agreement 0 12.00 Other Costs Under Agreement 0 13.00 13.00 Subtotal (sum of lines 11 through 13) 14 00 Ω 14 00 15.00 Medical Supplies 188, 811 15.00 16.00 Transportation (Health Care Staff) 2, 268 16.00 Depreciation-Medical Equipment 17.00 0 17.00 18.00 Professional Liability Insurance 18 00 0 19.00 Other Health Care Costs 0 0 19.00 Allowable GME Costs 20.00 20.00 21 00 Subtotal (sum of lines 15 through 20) 0 191, 079 21.00 0 22.00 Total Cost of Health Care Services (sum of 1, 911, 759 22.00 lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy 23.00 23.00 24.00 0 0 0 Dental 0 24.00 25.00 Optometry Λ 25.00 25. 01 Tel eheal th 8,892 25.01 25.02 Chronic Care Management C 25.02 All other nonreimbursable costs 0 26, 00 26.00 C 27.00 Nonallowable GME costs 27.00 Total Nonreimbursable Costs (sum of lines 23 28.00 0 8, 892 28.00 through 27) FACILITY OVERHEAD 29.00 29.00 Facility Costs 155, 218 30.00 Administrative Costs -1, 058 600, 689 30.00 31.00 Total Facility Overhead (sum of lines 29 and -1,058 755, 907 31.00

-1,058

2, 676, 558

32 00

32 00

and 31)

Total facility costs (sum of lines 22, 28

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
ANALYCIC OF HOCDITAL BACED DUC/FOLIC COCTC	Drovi don CCN, 1E 1210 Do	wind. Warkshoot M 1

Peri od: From 01/01/2023 ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS Provider CCN: 15-1310 Component CCN: 15-8542 То 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm RHC II Compensation Other Costs Total (col. 1 Reclassi fi cati Reclassi fied Trial Balance + col . 2) ons (col. 3 + col.4) 1.00 2.00 3.00 4.00 5.00 FACILITY HEALTH CARE STAFF COSTS 1.00 152, 904 873, 086 0 1.00 720, 182 873, 086 Physi ci an 2.00 Physician Assistant 2 00 157, 292 898, 146 3.00 Nurse Practitioner 740, 854 0 898, 146 3.00 0 4.00 Visiting Nurse 4.00 Other Nurse 5.00 597, 837 126, 928 724, 765 724, 765 5.00 0 6.00 Clinical Psychologist 0 6.00 7.00 Clinical Social Worker 0 0 7.00 7.10 Marriage and Family Therapist 7.10 Mental Health Counselor 7.11 7.11 8.00 Laboratory Techni ci an 8.00 9.00 Other Facility Health Care Staff Costs 527, 957 112, 092 640, 049 0 0 0 640, 049 9.00 Subtotal (sum of lines 1 through 9) 2, 586, 830 3, 136, 046 10.00 549, 216 3, 136, 046 10.00 11.00 Physician Services Under Agreement 0 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 Other Costs Under Agreement 0 13.00 0 0 13.00 0 0 Subtotal (sum of lines 11 through 13) 14 00 0 14 00 0 15.00 Medical Supplies 414, 084 414,084 414, 084 15.00 16.00 Transportation (Health Care Staff) 0 10, 653 10, 653 10, 653 16.00 0 17.00 Depreciation-Medical Equipment 17.00 C 0 Professional Liability Insurance 18 00 0 0 18 00 19.00 Other Health Care Costs 0 650 650 650 19.00 Allowable GME Costs 20.00 20.00 21 00 Subtotal (sum of lines 15 through 20) 0 425 387 425 387 0 425, 387 21 00 2, 586, 830 22.00 Total Cost of Health Care Services (sum of 974, 603 3, 561, 433 3, 561, 433 22.00 lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy 0 23.00 24.00 0 0 0 Dental 0 24.00 0 0 25.00 Optometry 0 Λ 25.00 Tel eheal th 8,803 8,803 25.01 7, 261 1,542 25.01 0 25.02 Chronic Care Management 25.02 0 0 All other nonreimbursable costs 26,00 0 0 Ω 26,00 27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 7, 261 1, 542 8,803 8,803 28.00 through 27) FACILITY OVERHEAD 29.00 Facility Costs 455, 772 455, 772 0 455, 772 29.00 30.00 Administrative Costs 826, 096 1, 350, 075 2, 176, 171 0 2, 176, 171 30.00 Total Facility Overhead (sum of lines 29 and 826, 096 1, 805, 847 2, 631, 943 0 2, 631, 943 31.00 31.00 Total facility costs (sum of lines 22, 28 32 00 3, 420, 187 2, 781, 992 6, 202, 179 6, 202, 179 32.00 and 31)

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1310	Period: Worksheet M-1 From 01/01/2023
	Component CCN: 15-8542	To 12/31/2023 Date/Time Prepared: 5/24/2024 1:32 pm

			·		5/24/2024 1:	32 pm
				 RHC I I		
		Adjustments	Net Expenses			
			for Allocation			
			(col. 5 + col.			
			6)			
		6. 00	7. 00			
	FACILITY HEALTH CARE STAFF COSTS					
1. 00	Physi ci an	C				1.00
2.00	Physi ci an Assi stant	C				2. 00
3.00	Nurse Practitioner	C	898, 146			3. 00
4.00	Visiting Nurse	C	0			4. 00
5.00	Other Nurse	C	724, 765			5. 00
6.00	Clinical Psychologist	C	0			6. 00
7.00	Clinical Social Worker	C	ol ol			7. 00
7.10	Marriage and Family Therapist					7. 10
7. 11	Mental Health Counselor					7. 11
8.00	Laboratory Techni ci an	C	ol ol			8.00
9.00	Other Facility Health Care Staff Costs	C	640, 049			9, 00
10.00	Subtotal (sum of lines 1 through 9)	C				10.00
11. 00	Physician Services Under Agreement	C				11. 00
12. 00	Physician Supervision Under Agreement	C				12.00
13. 00	Other Costs Under Agreement	C	-			13.00
	Subtotal (sum of lines 11 through 13)	C	-			14.00
	Medical Supplies	C	-			15. 00
16. 00	Transportation (Health Care Staff)		10, 653			16. 00
17. 00	Depreciation-Medical Equipment		0			17. 00
	Professional Liability Insurance					18. 00
	Other Health Care Costs		650			19.00
	Allowable GME Costs	C	050			20.00
20.00			425 207			
21. 00	Subtotal (sum of lines 15 through 20)	C				21. 00
22. 00	Total Cost of Health Care Services (sum of	C	3, 561, 433			22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES					
22.00		C	0			23.00
23. 00	Pharmacy	-	1			
24. 00	Dental	C				24. 00
25. 00	Optometry	C	0			25. 00
	Tel eheal th	C	8, 803			25. 01
	Chronic Care Management	C	0			25. 02
26. 00	All other nonreimbursable costs	C	0			26. 00
27. 00	Nonallowable GME costs					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	C	8, 803			28. 00
	through 27)					
	FACILITY OVERHEAD		1 .1			
	Facility Costs	C	1 .00,			29. 00
30. 00	Administrative Costs	-3, 304				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	-3, 304	2, 628, 639			31. 00
	30)					
32. 00	Total facility costs (sum of lines 22, 28	-3, 304	6, 198, 875			32. 00
	and 31)					

	Financial Systems PA TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ARKVIEW WABASH SERVICES	Provi der Co	CN: 15-1310	Peri od:	u of Form CMS-2 Worksheet M-2	
					From 01/01/2023		
			Component	CCN: 15-8541	To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
					RHC I	072172021 1.0	2 piii
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	3. 00	3)	<u>4</u> 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						1
1. 00	Physi ci an	1. 56	8, 389	4, 20	00 6, 552		1.00
2.00	Physici an Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 51	4, 118	2, 10	3, 171		3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 07	12, 507		9, 723	12, 507	4.00
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0. 00				0	6. 00
7. 00	Clinical Social Worker	0. 00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
7. 03	Marriage and Family Therapist						7. 03
7. 03	Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4	3. 07	12, 507			12, 507	8.00
	through 7)		,			,	
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOCDITAL BACE	D DUC /FOUR CED	VII CEC		1. 00	
10. 00				VICES		1, 911, 759	10.00
11. 00						8, 892	
12. 00	Cost of all services (excluding overhead) (s					1, 920, 651	
13. 00	Ratio of hospital -based RHC/FQHC services (I					0. 995370	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		755, 907	14.00
15. 00	Parent provider overhead allocated to facili			,		2, 010, 237	15. 00
16. 00						2, 766, 144	16. 00
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00						2, 766, 144	
	Overhead applicable to hospital-based RHC/FQ					2, 753, 337	1
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		4, 665, 096	20. 00

Hool +h	Financial Systems	ADVVIEW WADACH	HOSDITAL INC		In Lio	u of Form CMS-2	DEE2 10
	Financial Systems PA TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ARKVIEW WABASH SERVICES	Provider C	CN: 15-1310	Peri od:	Worksheet M-2	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
					RHC II		
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col . 1 x col .		
		1.00	2.00	3.00	3) 4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00	
	Posi ti ons						
1.00	Physi ci an	2. 13	10, 783	4, 20	0 8, 946		1. 00
2.00	Physician Assistant	0.00	0	2, 10	0		2. 00
3.00	Nurse Practitioner	7. 22	33, 914		0 15, 162		3. 00
4.00	Subtotal (sum of lines 1 through 3)	9. 35	44, 697		24, 108		4. 00
5.00	Visiting Nurse	0. 00	0			0	
6.00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0.00	0			0	
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00				0	7. 01 7. 02
7.02	only)	0.00	U			U	7.02
7. 03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	9. 35	44, 697			44, 697	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	N HOSPITAL-BASE	D RHC/FOHC SER	VLCES		1.00	
10.00	Total costs of health care services (from Wk					3, 561, 433	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,						11. 00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			3, 570, 236	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 997534	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		2, 628, 639	
15.00	Parent provider overhead allocated to facili	ty (see instruc	tions)			4, 620, 875	
16.00	Total overhead (sum of lines 14 and 15)					7, 249, 514	
17. 00 18. 00	Allowable GME overhead (see instructions) Enter the amount from line 16					0 7, 249, 514	17.00
	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 v line 1	8)		7, 249, 514	
	Total allowable cost of hospital-based RHC/F					10, 793, 070	
20.00	Trotal arrowable cost of hospital based know	2110 3CI VI CC3 (3	31 1111C3 10	. and 17)		10, 775, 070	20.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	SPITAL, INC. Provider CCN: 15-1310	Peri od: From 01/01/2023	w of Form CMS-2 Worksheet M-3	
ERVI CES	Component CCN: 15-8541	To 12/31/2023	Date/Time Pre 5/24/2024 1:3	
	Title XVIII	RHC I		
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
Total Allowable Cost of hospital-based RHC/FQHC Services (fro			4, 665, 096	1
.00 Cost of injections/infusions and their administration (from W .00 Total allowable cost excluding injections/infusions (line 1 m			206, 805 4, 458, 291	1
.00 Total Visits (from Wkst. M-2, column 5, line 8)			12, 507	
Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			12, 507 356. 46	
hajusted cost per visit (Time 3 divided by Time 0)		Cal cul ati on	of Limit (1)	7.0
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
		1. 00	12/31/2023) 2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00		8.0
Rate for Program covered visits (see instructions)		0.00	254. 25	9. 0
CALCULATION OF SETTLEMENT O.00 Program covered visits excluding mental health services (from	contractor records)	0	2, 058	10. (
1.00 Program cost excluding costs for mental health services (line		0	523, 247	
2.00 Program covered visits for mental health services (from contr	•	0	0	1
3.00 Program covered cost from mental health services (line 9 x li 4.00 Limit adjustment for mental health services (see instructions		0	0 0	
5.00 Graduate Medical Education Pass Through Cost (see instruction	*			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	523, 247	1
6.01 Total program charges (see instructions)(from contractor's re 6.02 Total program preventive charges (see instructions)(from prov	•		510, 715 16, 015	1
6.03 Total program preventive charges (see This factions) (110m prov 6.03 Total program preventive costs ((line 16.02/line 16.01) times			16, 408	1
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		368, 024	16.
(Titles V and XIX see instructions.) 6.05 Total program cost (see instructions)		0	384, 432	16. (
7.00 Primary payer amounts			0	1
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		46, 809	18. (
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		89, 498	19. (
records)				
0.00 Net program cost excluding injections/infusions (see instruct 1.00 Program cost of vaccines and their administration (from Wkst.	•		384, 432 32, 339	
1.50 Total program IOP OPPS payments (see instructions)	W-4, TITIE 10)		32, 339	21.
1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions)	minualina 21 (0)		417 771	21.
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 3.00 Allowable bad debts (see instructions)	minus iine 21.80)		416, 771 913	1
3.01 Adjusted reimbursable bad debts (see instructions)			593	1
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	1
5. 99 Demonstration payment adjustment amount before sequestration	-,		0	
6.00 Net reimbursable amount (see instructions)			417, 364	1
6.01 Sequestration adjustment (see instructions) 6.02 Demonstration payment adjustment amount after sequestration			8, 347 0	1
7. 00 Interim payments			376, 563	
8.00 Tentative settlement (for contractor use only)			0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda			32, 454 0	
chapter I, §115.2	nee with ows rub. 19-11,] 30.

ealth Financial Systems PARKVIEW WABASH HOS			u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1310	Peri od: From 01/01/2023	Worksheet M-3	
ERVI CES	Component CCN: 15-8542	To 12/31/2023	Date/Time Pre	pared
	·		5/24/2024 1:3	
	Title XVIII	RHC II		
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		10, 793, 070	1.
00 Cost of injections/infusions and their administration (from W			410, 027	1
Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		10, 383, 043	1
Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)		44, 697 0	1
OO Total adjusted visits (line 4 plus line 5)	7)		44, 697	6.
OO Adjusted cost per visit (line 3 divided by line 6)			232. 30	1
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
			12/31/2023)	
OO Day visit growest limit (from CNC Dub 100 OA shorter O COO	(1.00	2. 00	
OD Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 0. 00	221. 38 221. 38	
CALCULATION OF SETTLEMENT		0.00	221.30	7.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	4, 451	10.
1.00 Program cost excluding costs for mental health services (line		0	985, 362	11.
2.00 Program covered visits for mental health services (from contra	*	0	0	1
3.00 Program covered cost from mental health services (line 9 x li 4.00 Limit adjustment for mental health services (see instructions	•	0	0	
4.00 Limit adjustment for mental health services (see instructions 5.00 Graduate Medical Education Pass Through Cost (see instructions		U	U	15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	985, 362	
6.01 Total program charges (see instructions)(from contractor's re			963, 950	1
6.02 Total program preventive charges (see instructions)(from prov	-		35, 161	1
6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		35, 942	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		674, 653	16.
6.05 Total program cost (see instructions)		0	710, 595	16.
7.00 Primary payer amounts			0	1
B. 00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		106, 104	18.
records)) (6		1/4 210	10
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		164, 319	19.
0.00 Net program cost excluding injections/infusions (see instruct	i ons)		710, 595	20.
1.00 Program cost of vaccines and their administration (from Wkst.			52, 593	1
1.50 Total program IOP OPPS payments (see instructions)				21.
1.55 Total program IOP Costs (see instructions)				21.
1.60 Program IOP deductible and coinsurance (see instructions) 2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1	minus lina 21 60)		763, 188	21.
3.00 Allowable bad debts (see instructions)	illi lius Ti lie 21.00)		879	
3. 01 Adjusted reimbursable bad debts (see instructions)			571	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	
5.99 Demonstration payment adjustment amount before sequestration 6.00 Net reimbursable amount (see instructions)			0 763, 759	
6.01 Sequestration adjustment (see instructions)			15, 275	
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			695, 774	
3.00 Tentative settlement (for contractor use only)	00 07 1		0	1
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0			52, 710	
D.00 Protested amounts (nonallowable cost report items) in accorda	nce with CMS PUB. 15-11,		0	30.

OMPUT	FATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 15-1310	Peri od:	Worksheet M-4	
		Component (CCN: 15-8541	From 01/01/2023 To 12/31/2023		
			XVIII	RHC I		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 720, 680 0. 001004	· · ·			1. 0 2. 0
. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 728	4, 7!	53 0	0	3. (
. 00	Injections/infusions and related medical supplies costs (from your records)	58, 760			0	4. (
. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	60, 488 1, 911, 759			0 1, 911, 759	5. (6. (
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	2, 753, 337 0. 031640	· · ·			7. (8. (
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	87, 116 147, 604			0 0	9. (10. (
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	312 473. 09 44			0 0.00 0	12.
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	20, 816	11, 5:	23 0	0	14. (
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1. 00	2.00			
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		206, 805	15.
4 00	00 Total Program cost of injections/infusions and their administration costs (sum of				32, 339	1/

	Financial Systems PARKVIEW WABASH TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 15-1310	Peri od:	worksheet M-4	
		Component (CCN: 15-8542	From 01/01/2023 To 12/31/2023		
		Title	XVIII	RHC II		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	3, 136, 046 0. 001241	0. 0026	0. 000000		
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	3, 892	8, 2		0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	88, 733	34, 3		0	4.00
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	92, 625 3, 561, 433	42, 6 3, 561, 4		0 3, 561, 433	5. 00 6. 00
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	7, 231, 637 0. 026008	7, 231, 6 0. 0119			7. 00 8. 00
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	188, 080 280, 705	86, 6, 129, 3		0	
11. 00 12. 00 13. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	843 332. 98 89	1, 7 ⁰ 71. ⁰ 3		ı "	12.00
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 0°
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	29, 635	22, 9	58 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		410, 027	15. 00
16. 00					52, 593	16.0

Health Financial Systems	PARKVIEW WABASH HOS	In Lieu of Form CMS-2552-10				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1310 Component CCN: 15-8541	From 01/01/2023			
		Component Con. 15-8541		5/24/2024 1:32 pm		

		·		5/24/2024 1: 3	2 pm
			RHC I		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
	Total interim payments paid to hospital-based RHC/FQHC			376, 563	1.
				0	2.
	the contractor for services rendered in the cost reporting $\boldsymbol{\mu}$	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3.
04				0	3.
.05				0	3.
	Provider to Program				
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54		202		0	3.
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3.
	Total interim payments (sum of lines 1, 2, and 3.99) (transf 27)	er to worksheet M-3, line		376, 563	4.
	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after desk	roviow Also show data of			5.
	each payment. If none, write "NONE" or enter a zero. (1)	review. Also show date of			٥.
	Program to Provider				
01	Trogram to Trovidor			0	5.
02				l ol	5.
03				0	5.
	Provider to Program			_	
50				0	5.
51				l ol	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			32, 454	6.
	SETTLEMENT TO PROGRAM			0	6.
	Total Medicare program liability (see instructions)			409, 017	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor				8.

Health Financial Systems	PARKVIEW WABASH HOS	In Lieu of Form CMS-2552-10				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1310 Component CCN: 15-8542	From 01/01/2023			
		Component CCN, 15-8542		5/24/2024 1:32 pm		

		'		5/24/2024 1: 32	2 pm
			RHC II		
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			695, 774	1.
2. 00	On Interim payments payable on individual bills, either submitted or to be submitted to			0	2.
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		695, 774	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				_
00	List separately each tentative settlement payment after desk	c review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider				-
01				0	5 5
02 03				0	5 5
03	Drawi dan ta Drawan			0	5
50	Provider to Program			0	5
50 51					5
52					5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				5
00	Determined net settlement amount (balance due) based on the			١	6
01	SETTLEMENT TO PROVIDER	cost report. (1)		52, 710	6
02	SETTLEMENT TO PROVIDER			52, 710	6
00	Total Medicare program liability (see instructions)			748, 484	7
00	Total medicale program frability (see instructions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	