	al Systems ORTHOPAEDIC HOSPT. s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being	lure to report can resul	t in all interim	u of Form CMS-2552-10 FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/23/2020 1:28 pm
PART I - COST				
Provi der use only	 [X] Electronically prepared cost report [] Manually prepared cost report 3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or " 	of times the provider re	Date: 6/23/20 esubmitted this co	·
Contractor use only	5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	10.N 11.C or this Provider CCN 12.[IPR Date: Contractor's Vendo 0]If line 5, cc number of tim	or Code: 4 Jumn 1 is 4: Enter nes reopened = 0-9.
ADMINISTRATIVE PROVIDED OR PE	TIFICATION FION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN T E ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. ROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A E ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	FURTHERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE
CERTI	FICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR O	F PROVIDER(S)		
el ect Expen 01/01 corre i nstri provi	EBY CERTIFY that I have read the above certification so ronically filed or manually submitted cost report and ses prepared by ORTHOPAEDIC HOSPT. AT PARKVIEW (15-016/ /2019 and ending 12/31/2019 and to the best of my know ct, complete and prepared from the books and records of uctions, except as noted. I further certify that I am sion of health care services, and that the services ide i ance with such laws and regulations.	the Balance Sheet and Sta 7) for the cost reportin ledge and belief, this re f the provider in accorda familiar with the laws a	atement of Revenue ng period beginnin eport and statemen ance with applical and regulations re	e and ng nt are true, ble egarding the
	I have read and agree with the above certification sta signature on this certification statement to be the le			
	(Si gned			
		Officer or Admini	strator of Provid	er(s)
		SVP/CF0		
		Title		
		(Dated when report Date	is electronicall	y signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY				_		
1.00	Hospi tal	0	11, 576	22, 373	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	11, 576	22, 373	0	0	200.00

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

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	.TA	Provi d	er CC	N: 15-0167	Period: From 01/ To 12/	01/2019 31/2019	Part I Date/1	neet S-2 	epared
	1.00		00		3.00			4.00			
	Hospital and Hospital Health Care Co Street: 11119 PARKVIEW PLAZA DRIVE	PO Box:									1.
	City: FORT WAYNE	State: I	N	Zip Cod	e: 468	45-1705 Cou	nty: ALLEN				2.
		Component Na		CCN Number	CBS Numb		er Date Certifi		ent Sys T, O, or XVIII	rN)	
		1.00		2.00	3.0	0 4.00	5.00	6.0			1
	•	t Identification: ORTHOPAEDIC HOSP		150167	230		11/08/2		P	P	3.
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - FQHC Hospital -Based (CMHC) I	PARKVI EW									4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17.
00	Renal Dialysis										18.
	Other										19.
								°om:		0:	_
00	Cost Reporting Period (mm/dd/yyyy)							. 00 1/2019		. 00 1/2019	20.
	Type of Control (see instructions)						0170	4	12/3	1/2019	20
00								•			
	Inpatient PPS Information					1.00	2	. 00	3.	. 00	
01	disproportionate share hospital adjus §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §- hospital?) In column 2, enter "Y" for Did this hospital receive interim unc cost reporting period? Enter in colum- the portion of the cost reporting peri- Enter in column 2, "Y" for yes or "N" reporting period occurring on or after Is this a newly merged hospital that payments to be determined at cost report Enter in column 1, "Y" for yes or "N"	r yes or "N" for 412.106(c)(2)(Pic r yes or "N" for compensated care mn 1, "Y" for yes riod occurring pr " for no for the er October 1. (se requires final u port settlement? " for no, for the	no. Is the ckle amend no. payments s or "N" f rior to Oc portion oc portion co uncompensa (see instruct uncompensa (see inst	his dment for thi for no f ctober 1 of the c ctions) ated car tructior of the	s For cost re ls)	N		N			22.
	cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for i reporting period occurring on or afte	e cost reporting ic reclassificati ds for delineatir olumn 1, "Y" for g period prior to no for the portic er October 1. (se	period or on from u ng statist yes or "N o October on of the ee instruc	n or aft urban to tical ar N" for r 1. Ente cost ctions)	er eas io r	Ν		N		N	22.
00	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Which method is used to determine Mee below? In column 1, enter 1 if date of if date of discharge. Is the method of reporting period different from ther reporting period? In column 2, enter	2.105)? Enter in dicaid days on li of admission, 2 i of identifying th method used in th	column 3, nes 24 ar f census ne days ir ne prior c	"Y" fo nd/or 25 days, c n this c cost	or 5 9 r 3		3	N			23.
			In-State Medicaic paid day	e In-S d Medi s elig unp da	caid ible aid ys	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medi ca HMO da	ays Me	Other edi cai d days	_
00	If this provider is an IPPS hospital,	enter the	1.00	0	00	3.00	4.00	5.00	0	6.00	24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in			U	. 0			0	C	24.

	Financial Systems ORTHOPAED AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-0167	Peri od:	In Lieu		et S-2	
					From 01/0 To 12/3	1/2019	Part I Date/Ti 6/23/20		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medi cai HMO day	ys Med	ther di cai d days	
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1.00 0	2.00 0	3.00	4.00	5.00	0	5.00	25.
					Urban/R		Date of 2.		
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. age) status "2" for r	at the enc ural. If ap	d of the cos		1			26.
00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
					Begi nr 1. C		Endi 2.		
00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	er				36
		the numbe	•		s	0			37
	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes or "	N" for no.	(see					
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/		Y/ 2.		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob), (ii), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremer in column 2 t? Enter "Y	ter in colum nts in 2 "Y" for ye (" for yes o	n s r N		N		39 40
	no in column 2, for discharges on or after October 1.					V	XVIII	XIX	
	Description Description (DDC) Conital					1.00	_	3.00	_
00	<u>Prospective Payment System (PPS)-Capital</u> Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	te share in	accordance	N	N	N	45
00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.			5		N	N	N	46
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS on Is the facility electing full federal capital payment Teaching Hospitals	•		2		N N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (N			56
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period duri yes or "N th of this (", complet , if appli	ng which re "for noir cost report e Worksheet cable.	n column 1. ting period? t E-4. lf co	lf column 1 Enter "Y" lumn 2 is				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	s as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	35 Worksh Line	2 #	Pass-T Qualifi Criteri	cation	
				1.00	2.0	00	3.	00	-
. 00	Are you claiming nursing and allied health education 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	85? (see umn 1. If	column 1	N			0.1		60.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2019 o 12/31/2019		pared:
		Y/N	IME	Direct GME	IME	6/23/2020 1:2 Direct GME	8 pm
		1.00	2.00	3.00	4.00	5.00	1
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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)	N			0.00	0.00	61.0
1. 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. C
1. 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)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. C
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. C
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1		1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, 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. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61.1
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
2.00 2.01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	uctions)	N	63.0
				Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovid	der Settings	1.00 This base vear	2.00 is vour cost r	<u> </u>	
4.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care a 3 the ratio	0. 00	-		64.0

	EX IDENTIFICATION DA	ATA Provi der	Fr	eriod: com 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 6/23/2020 1:2	pared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	1
			FTEs	FTEs in	$(\operatorname{col} \cdot 3 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20 ⁻		n Nonprovider Settir	ngsEffective fo	r cost reporti	ing periods	
Enter in column 2 the number of u	unweighted non-prima	ry caro rocidont				
FTEs that trained in your hospita (column 1 divided by (column 1 +		3 the ratio of	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
(column 1 divided by (column 1 +	column 2)). (see in	3 the ratio of structions)	FTĔs Nonprovider	FTEsin	(col. 3 + col. 4)) 5.00	_
(column 1 divided by (column 1 +	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
<pre>(column 1 divided by (column 1 + (column 1 divided by (column 1 + 00 Enter in column 1, the program 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</pre>	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital 4.00 0.00	(col. 3 + col. 4)) 5.00 0.000000	_
<pre>(col umn 1 divided by (col umn 1 + (col umn 1 divided by (col umn 1 + name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions)</pre>	<u>column 2)). (see in</u> Program Name	3 the ratio of structions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	_
<pre>(col umn 1 divided by (col umn 1 +</pre>	<u>column 2)). (see in</u> Program Name <u>1.00</u> 25	3 the ratio of structions) Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
<pre>(column 1 divided by (column 1 + (column 1 divided by (column 1 + 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)</pre>	column 2)). (see in Program Name 1.00 1.00 value yalue yalue	3 the ratio of structions) Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	70.
<pre>(col umn 1 divided by (col umn 1 +</pre>	column 2)). (see in Program Name 1.00 1.00 via the facility (interpretent of the facility for the facility have a sefore November 15, 2 umn 2: Did this fac at 12.424 (d)(1)(ii) cate which program y y PPS	3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0 2.00 3.00 0 0 0 2.00 3.00	_

Health Financial Systems ORTHO	PAEDIC HOSPT	. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	N DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/23/2020 1:2	epared:
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter 81.00 Is this a LTCH co-located within another hospital "Y" for yes and "N" for no.	2			g period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.86.00Did this facility establish a new Other subprovid	ler (excluded				N	85. 00 86. 00
<pre>§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for 87.00 Is this hospital an extended neoplastic disease of 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for n</pre>	are hospital	classi fied u	under section		Ν	87.00
	10.			V 1.00	XI X 2.00	_
Title V and XIX Services	ant haanital		aton "V" for			00.00
90.00 Does this facility have title V and/or XIX inpati yes or "N" for no in the applicable column.	ent nospitai	Services? El	nter Y Tor	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XI full or in part? Enter "Y" for yes or "N" for no				Ν	Ν	91.00
92.00 Are title XIX NF patients occupying title XVIII S instructions) Enter "Y" for yes or "N" for no in	SNF beds (dua	al certificati			Ν	92.00
93.00 Does this facility operate an ICF/IID facility for "Y" for yes or "N" for no in the applicable colum	or purposes o		d XIX? Enter	N	Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y applicable column.	/" for yes, a	and "N" for no	o in the	N	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage 96.00 Does title V or XIX reduce operating cost? Enter				0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00 f line 96 is "Y", enter the reduction percentage	5			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) stepdown adjustments on Wkst. B, Pt. I, col. 25?	for the in Enter "Y" fo	terns and resi	idents post	Y	Y	98.00
<pre>column 1 for title V, and in column 2 for title X 98.01 Does title V or XIX follow Medicare (title XVIII) C, Pt. I? Enter "Y" for yes or "N" for no in colu </pre>	for the rep				Y	98. 01
<pre>title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y</pre>				Y	Y	98. 02
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) reimbursed 101% of inpatient services cost? Enter 	for a criti "Y" for yes	ical access ho s or "N" for i	ospital (CAH) no in column	N	Ν	98. 03
 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) outpatient services cost? Enter "Y" for yes or "N 				Ν	Ν	98. 04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N"</pre>					Y	98. 05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) Pts. I through IV? Enter "Y" for yes or "N" for n column 2 for title XIX.</pre>	when cost n no in column	reimbursed for 1 for title ^v	r Wkst. D, V, and in	Y	Y	98.06
Rural Providers 105.00Does this hospital qualify as a CAH?				N		105.00
106.00 If this facility qualifies as a CAH, has it elect for outpatient services? (see instructions)	ed the all-i	nclusive met	hod of paymen			106.00
107.00 Column 1: If line 105 is Y, is this facility elig training programs? Enter "Y" for yes or "N" for n	no in column	1. (see ins	tructions)			107.00
Column 2: If column 1 is Y and line 70 or line 7 approved medical education program in the CAH's e Enter "Y" for yes or "N" for no in column 2. (se	excluded IPI	, F and/or ΙRF ι				
108.00 Is this a rural hospital qualifying for an except CFR Section §412.113(c). Enter "Y" for yes or "N"	ion to the (dul e? See 42	N		108.00
	-	Physi cal 1.00	Occupationa 2.00	I Speech 3.00	Respi ratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost pro therapy services provided by outside supplier? En for yes or "N" for no for each therapy.		N	2.00			109.00
			1		4.00	
110.00 Did this hospital participate in the Rural Commun					1.00 N	110.00
Demonstration)for the current cost reporting peri complete Worksheet E, Part A, lines 200 through 2 applicable.						

Health Financial Systems ORTHOPAEDIC HOSPT. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AT PARKVIEW Provider CC	N: 15 0147	In Lie Period:	eu of Form CMS- Worksheet S-:	
NOSPITAL AND NOSPITAL REALIN CARE COMPLEX IDENTIFICATION DATA	Provider CC		From 01/01/2019 To 12/31/2019	Part I	epared:
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting p umn 1 is Y, e icipating in	eriod? Enter enter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting part Enter "Y" for yes or "N" for no in column 1. If column 1 is " in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscell aneous Cost Reporting Information	eriod? "Y", enter	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or ' in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers; the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) " percent ncludes) based on	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" fo "N" for no.	5	N			116.00
117.00 s this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	nce? Enter	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence polic if the policy is claim-made. Enter 2 if the policy is occurren			1		118.00
118.01 List amounts of malpractice premiums and paid losses:		1. 00 270, 58	2.00	3. 00 229, 45	9 118. 01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost control Administrative and General? If yes, submit supporting schedul and amounts contained therein. 119.00 D0 NOT USE THIS LINE			N		118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" lifies for th	for yes or ne Outpatient	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices	charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 in the Worksheet A line number where these taxes are included.			N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, ento	er the certif	ication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	r the certifi	cation date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	r the certifi	cation date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter	the certific	ation date ir	1		129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, en		i fi cati on			130.00
date in column 1 and termination date, if applicable, in colum 131.00 If this is a Medicare certified intestinal transplant center,	enter the ce	erti fi cati on			131.00
date in column 1 and termination date, if applicable, in colum 132.00 If this is a Medicare certified islet transplant center, enter		cation date			132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	OPO number i	n column 1			133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as de	fined in CMS	Pub 15_1	Y	15H032	140.00

leal th Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ORTHOPAEDIC X IDENTIFICATION DATA			N: 15-0167	Perio From To	od: 01/01/2019	u of Form CMS Worksheet S- Part I Date/Time Pr 6/23/2020 1:	-2 repared:
1.00		2.00				3.00	072372020 1.	20 pm
If this facility is part of a cha					e name a	and address	of the	
141.00 Name: PARKVIEW HEALTH SYSTEM, IN		e: WISCONSIN			ictor's	Number: 0810	1	141.00
142.00 Street: 10501 CORPORATE DRIVE	PO Box:	SERVI CE 5600						142.00
143.00 City: FORT WAYNE	State:	IN		Zip Cc	ode:	4689	5-5600	143.00
							1.00	-
144.00 Are provider based physicians' cos	sts included in Worksh	eet A?					N	144.00
						1.00	0.00	_
45.00 If costs for renal services are cl	aimed on Wkst A lin	e 74 are t	he costs	for		1.00	2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	' for yes or "N" for n clude Medicare utiliza for no in column 2. gy changed from the pr	o in column tion for th eviously fi	1. If co is cost i led cost	olumn 1 is reporting report?		N		146. 00
yes, enter the approval date (mm/d		db. 15 2, c		3, 3, 2020)				
							1.00	_
147.00Was there a change in the statisti	cal basis? Enter "Y"	for ves or	"N" for i	10.			1.00 N	147.00
148.00 Was there a change in the order o 149.00 Was there a change to the simplifi	f allocation? Enter "Y	" for yes o	r "N" fo	r no.	or po		N	148.0
	ea cost innung metho		rt A	Part E		Title V	Title XIX	177.00
			00	2.00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							. 13)	
55.00 Hospi tal			N	N		N	N	155. C
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N		N N	N N	156. C
58. 00 SUBPROVI DER								158.0
59. 00 SNF			N	Ν		Ν	N	159.0
160.00HOME HEALTH AGENCY 161.00CMHC			N	N N		N N	N N	160. 0 161. 0
		I	1					_
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	s one or mo	re campus	ses in dif	ferent	CBSAs?	N	165. 0
	Name	Coun			Zip Cod		FTE/Campus	_
166.00 If line 165 is yes, for each	0	1.0	0	2.00	3.00	4.00	5.00	00 166. 0
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								
							1.00	_
Health Information Technology (HI						t	-	
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	05 is "Y") and is a me	aningful us				er the	Y	167. C 168. C
reasonable cost incurred for the H 68.01 If this provider is a CAH and is n	not a meaningful user,	does this				irdshi p		168. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful u	user (line 167 is "Y")					enter the	9.0	99169. 0
transition factor. (see instruction	ons)					Begi nni ng	Endi ng	
						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and end	ing date fo	r the re	porting				170. 0
						1.00	2.00	

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0167	Peri od: From 01/01/2019 To 12/31/2019 Y/N		epared:
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lforall NO re	esponses. Ente			
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.00
		<u> </u>	Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum		N	2.00	0.00	2.00
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, ailable in	Y	R	03/26/2020	4.00
	those on the filed financial statements? If yes, submit rec					
				Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.00
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		I during the	N		7.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	0			9.00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		he current	Ν		10.00
1. 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	Ν	V (N	11.00
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13.0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> t A	tructions. Par	n N	15.00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.00
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	05/01/2020	Y	05/01/2020	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.00

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ORTHOPAEDI C HOSPT. AT PARKVI EW

In Lieu of Form CMS-2552-10

	e during the cost st reporting period? riod? If yes, see	6/23/2020 1 Y/N 3.00 N Date 4.00 1.00 N N	20.00 21.00 21.00 22.00 23.00 24.00 25.00
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: Y/N Da 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 1.00 2.1 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 1.00 2.1 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 1.00 2.1 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	N ite Y/N 00 3.00 N S) le during the cost ist reporting period? iriod? If yes, see	N Date 4.00 1.00	21.00 21.00 22.00 23.00 24.00
Report data for Other? Describe the other adjustments: Y/N Da 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? 25.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	s)	Date 4.00	21.00 21.00 22.00 23.00 24.00
Y/N Da 21.00 Was the cost report prepared only using the provider's records? If yes, see instructions. N 21.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS Capital Related Cost N 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions See instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting periods. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	00 3.00 N S) le during the cost st reporting period? riod? If yes, see	4.00	22. 00 23. 00 24. 00
21.00 Was the cost report prepared only using the provider's N records? If yes, see instructions. N COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	S) e during the cost st reporting period? riod? If yes, see	1.00 N	22. 00 23. 00 24. 00
records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	S) le during the cost st reporting period? riod? If yes, see	N	22. 00 23. 00 24. 00
 Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting periods. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period 	e during the cost st reporting period? riod? If yes, see	N	23. 00 24. 00
 Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting periods. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period 	e during the cost st reporting period? riod? If yes, see	N	23. 00 24. 00
 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost if yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period. 	st reporting period? riod? If yes, see		23. 00 24. 00
 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this constitutions. 25.00 Have there been new capitalized leases entered into during the cost reporting period instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period. 	st reporting period? riod? If yes, see		23. 00 24. 00
 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this configurations. 25.00 Have there been new capitalized leases entered into during the cost reporting period instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period. 	st reporting period? riod? If yes, see	N	24.00
 24.00 Were new leases and/or amendments to existing leases entered into during this cost of the second se	riod?lfyes, see		
 25.00 Have there been new capitalized leases entered into during the cost reporting per instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period 	3		25.00
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period	3		ZO. UU
	od?lfyes, see		
			26.00
27.00 Has the provider's capitalization policy changed during the cost reporting period	d?lfyes, submit	N	27.00
copy. Interest Expense			_
28.00 Were new loans, mortgage agreements or letters of credit entered into during the	cost reporting	N	28.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Servi	ice Reserve Fund)	N	29.00
treated as a funded depreciation account? If yes, see instructions			
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? In instructions.	f yes, see	N	30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? Is	f yes, see	Ν	31.00
instructions. Purchased Services			_
32.00 Have changes or new agreements occurred in patient care services furnished throug	gh contractual	N	32.00
arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to con	mpetitive biddina? If	-	33.00
no, see instructions.			
Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provide	ar bacad physicians?	N	24 00
If yes, see instructions.	er-based physicians?	IN	34.00
35.00 If line 34 is yes, were there new agreements or amended existing agreements with	the provider-based		35.00
physicians during the cost reporting period? If yes, see instructions.	Y/N	Date	
	1.00	2.00	
Home Office Costs	Y	1	
36.00 Were home office costs claimed on the cost report?37.00 If line 36 is yes, has a home office cost statement been prepared by the home office			36.00 37.00
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home office different from the	at of N		38.00
the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00 If line 36 is yes, did the provider render services to other chain components? In see instructions.	fyes, N		39.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes,	see N		40.00
i nstructi ons.			_
1.00	2	. 00	
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position ERIC	NI CKESON		41.00
held by the cost report preparer in columns 1, 2, and 3,			41.00
42.00 Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM	MINC		42.00
preparer.			
43.00 Enter the telephone number and email address of the cost (260) 373-8406 report preparer in columns 1 and 2, respectively.	ERI C. NI CKESON	PARKVI EW. COM	43.00

Heal th	Financial Systems ORTHOPAEDIC H	OSPT. AT PARKVI EW	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0167	Peri od:	Worksheet S-2 Part II	
			From 01/01/2019 To 12/31/2019		pared: 8 pm
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	DI RECTOR, REI MBURSEMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

	Financial Systems OI AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RTHOPAEDIC HOSP AL DATA	Provider CC	N. 15-0167	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 6/23/2020 1:2	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00	37	13, 5		0.00	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 I PF Subprovi der						3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.0
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.0
7.00	Total Adults and Peds. (exclude observation		37	13, 5	0.00	0	7.00
	beds) (see instructions)						
3.00							8.0
0.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. C
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY						13.0
4.00	Total (see instructions)		37	13, 5	0. 00	0	14. C
5.00	CAH visits					0	15.0
6.00	SUBPROVI DER – I PF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.0
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC – CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		37			0	27.
8.00 9.00	Observation Bed Days Ambulance Trips					0	28. 29.
9.00 D.00	Employee discount days (see instruction)						30.
1.00	Employee discount days (see first detroit)						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.
2.01	Total ancillary labor & delivery room		Ŭ				32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. C
3. 01	LTCH site neutral days and discharges						33.0

1051 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0167		eriod: com 01/01/2019 o 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/23/2020 1:2	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		[
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	1, 370 1, 263 0	269 261 0	4, 47	74			1.00 2.00 3.00
1.00	HMO IPF Subprovider HMO IRF Subprovider	0	0					4.00
F. 00 5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
5.00	Hospital Adults & Peds. Swing Bed Ski Hospital Adults & Peds. Swing Bed NF	U	0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 370	269	4, 47				7.00
3. 00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNI T							9.00
0.00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.00
3.00	NURSERY							13.00
4.00	Total (see instructions)	1, 370	269	4,47	74	0.00	175.14	14.00
5.00	CAH visits	0	0		0			15.00
6.00	SUBPROVIDER - IPF							16.0
7.00	SUBPROVIDER - IRF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY							19.0
0.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)					0.00	0.00	
4.00	HOSPICE							24.0
4. 10	HOSPICE (non-distinct part)				0			24. 1
5.00	CMHC - CMHC							25. C
6.00	RURAL HEALTH CLINIC				_			26. C
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00		
7.00	Total (sum of lines 14-26)					0.00	175.14	
8.00	Observation Bed Days		16	1, 25	56			28.0
9.00	Ambul ance Trips	0						29.0
0.00	Employee discount days (see instruction)			10	01			30.0
1.00	Employee discount days - IRF	_	_		0			31.0
2.00	Labor & delivery days (see instructions)	0	0		0			32.0
2. 01	Total ancillary labor & delivery room				0			32.0
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0						33.0

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/23/2020 1:2	pared:
		Full Time Equivalents		Di s	charges	•	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.25 27.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SCILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00	0	6	65 5 65 5 65 5	2, 666	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 24. 00 25. 00 24. 00 26. 00 27. 00 26. 00 27. 00 27. 00 28. 00 29. 00 20. 00
28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 22. 01	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 33. 0 33. 0

PI T.	Financial Systems AL WAGE INDEX INFORMATION			Provider CC	1	Period: From 01/01/2019 Fo 12/31/2019		par
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	_
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200. 00	24, 449, 940	13, 299, 965	37, 749, 90	5 1, 105, 748. 00	34.14	·
0	instructions) Non-physician anesthetist Part		(0 0	(0.00	0.00	
0	A Non-physician anesthetist Part		(0 0	(0.00	0.00)
0	B Physician-Part A -		(0 0	(0.00	0. 00	
1	Administrative Physicians – Part A – Teaching		ſ		(0.00	0.00	
C	Physician and Non Physician-Part B		(0 0		0.00		
0	Non-physician-Part B for hospital-based RHC and FQHC services		(0 0	(0.00	0. 00	
C	Interns & residents (in an	21.00	(o o	(0.00	0. 00	
1	approved program) Contracted interns and residents (in an approved		(0 0	(0.00	0. 00	
0	programs) Home office and/or related organization personnel		(9, 765, 340	9, 765, 340	250, 997. 00	38. 91	
0 00	SNF Excluded area salaries (see	44.00	(11, 113, 281	0 2, 560, 882	(13, 674, 16	0.00 3 448,900.00		
	instructions) OTHER WAGES & RELATED COSTS		,,	2,000,002				.
00	Contract Labor: Direct Patient		(0 0	(0.00	0.00	1
00	Care Contract Labor: Top Level management and other		(0 0	(0.00	0. 00	1
00	management and administrative services Contract Labor: Physician-Part		(0	(0.00	0. 00) 1
00	A - Administrative Home office and/or related		(o o	(0.00	0. 00) 1
	organization salaries and wage-related costs							
)1)2	Home office salaries		(9, 765, 340	250, 997. 00 0. 00		
	Related organization salaries Home office: Physician Part A		(0.00		
00	- Administrative Home office and Contract		(0 0	(0.00	0.00) 1
)1	Physicians Part A - Teaching Home office Physicians Part A		(0 0	(0.00	0. 00) 1
)2	- Teaching Home office contract		(0 0	(0.00	0. 00) 1
_	Physicians Part A - Teaching WAGE-RELATED COSTS					-		1
	Wage-related costs (core) (see instructions)		7,006,361	0	7, 006, 36			1
0	Wage-related costs (other) (see instructions)							1
0	Excluded areas Non-physician anesthetist Part A		3, 979, 363 (3 O D O	3, 979, 363 (3 D		2
00	Non-physician anesthetist Part B		(0 0	(D		2
0	Physician Part A - Administrative		(0 0	(D		2
)1	Physician Part A - Teaching		(0	(D		2
0 0 0	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an				(
0	approved program) Home office wage-related		3, 045, 236	5 O	3, 045, 236	6		2
51	(core) Related organization		(0 0	(D		2
52	wage-related (core) Home office: Physician Part A - Administrative -		(0 0	(D		2

	Financial Systems	Uh	THUPAEDIC HUSE	PT. AT PARKVIEW			u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part II Date/Time Pre 6/23/2020 1:23	pared
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.5
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	1, 515, 810			0 0.00		26. (
27.00	Administrative & General	5.00	1, 015, 878	8, 981, 933	9, 997, 81			
28.00	Administrative & General under		0	0		0.00	0.00	28.
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.
30.00	Operation of Plant	7.00	0	152, 152	152, 15			
31.00	Laundry & Linen Service	8.00	0	0		0.00		31.
32.00	Housekeepi ng	9.00	246, 614	79, 768	326, 38	2 19, 692. 00		
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.
34.00	Dietary	10.00	0	192, 953	192, 95	3 4, 959. 00	38. 91	34.
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.
36.00	Cafeteri a	11.00	0	0		0.00	0.00	36.
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.
38.00	Nursing Administration	13.00	0	0		0.00	0.00	38.
39.00	Central Services and Supply	14.00	0	29, 727	29, 72	7 764.00	38. 91	39.
40.00	Pharmacy	15.00	0	2, 390	2, 39	0 61.00	39. 18	40.
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00	0.00	41.
42.00	Soci al Servi ce	17.00	259, 834	16, 272	276, 10	6 7, 519. 00	36. 72	42.
43.00	Other General Service	18.00	0	0		0.00	0.00	43

Heal th	Financial Systems	OI	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2019 To 12/31/2019		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1				
1.00	Net salaries (see		24, 449, 940	3, 534, 625	27, 984, 56	5 854, 751. 00	32.74	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		11, 113, 281	2, 560, 882	13, 674, 16	3 448, 900. 00	30.46	2.00
3.00	Subtotal salaries (line 1		13, 336, 659	973, 743	14, 310, 40	2 405, 851.00	35.26	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		0	9, 765, 340	9, 765, 34	0 250, 997. 00	38. 91	4.00
5.00	Subtotal wage-related costs		10, 051, 597	0	10, 051, 59	7 0.00	70. 24	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		23, 388, 256	10, 739, 083	34, 127, 33	9 656, 848. 00	51.96	6.00
7.00	Total overhead cost (see		3, 038, 136	7, 939, 385	10, 977, 52	1 279, 661.00	39. 25	7.00
	instructions)			I	l	1	I	

	Financial Systems ORTHOPAEDIC HOSE AL WAGE RELATED COSTS	PT. AT PARKVIEW Provider CCN: 15-0167	Peri od:	u of Form CMS-2 Worksheet S-3	
			From 01/01/2019	Part IV	
			To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				1
	RETI REMENT COST				1
. 00	401K Employer Contributions			0	1.
00	Tax Sheltered Annuity (TSA) Employer Contribution			573, 669	2.
. 00	Nonqualified Defined Benefit Plan Cost (see instructions)			1, 988, 235	3.
. 00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
. 00	401K/TSA Plan Administration fees			0	
. 00	Legal/Accounting/Management Fees-Pension Plan			2, 887	6.
00	Employee Managed Care Program Administration Fees			85, 352	7.
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	
01	Health Insurance (Self Funded without a Third Party Adminis			0	
02	Health Insurance (Self Funded with a Third Party Administra	tor)		5, 705, 593	
03	Health Insurance (Purchased)			0	
00	Prescription Drug Plan			0	
0. 00	Dental, Hearing and Vision Plan			0	
. 00	Life Insurance (If employee is owner or beneficiary)			83, 452	
2.00	Accident Insurance (If employee is owner or beneficiary)			0	
3.00	Disability Insurance (If employee is owner or beneficiary)			116, 143	
. 00	Long-Term Care Insurance (If employee is owner or beneficia	iry)		0	1
6.00	'Workers' Compensation Insurance			33, 804	
5.00	Retirement Health Care Cost (Only current year, not the ext	raordinary accrual require	ed by FASB 106.	0	16.
	Non cumulative portion) TAXES				
,	FICA-Employers Portion Only			2, 231, 135	1 17
	Medicare Taxes - Employers Portion Only			2,231,135	
	Unemployment Insurance			0	
	State or Federal Unemployment Taxes			0	
, 00	OTHER			0	20.
00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on Lines 1 throu	igh 4 above (see	64, 378	21
. 00	instructions))	Reported on Trites 1 through	agii 4 above. (See	04, 370	21.
2.00	Day Care Cost and Allowances			0	22.
	Tuition Reimbursement			101, 076	
	Total Wage Related cost (Sum of lines 1 -23)			10, 985, 724	
	Part B - Other than Core Related Cost				1
5 00	OTHER WAGE RELATED COSTS (SPECIFY)				25.

Heal th	Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0167	Peri od:	Worksheet S-3	
			From 01/01/2019	Part V	
			To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Iden	ti fi cati on:			
1.00	Total facility's contract labor and benefi	t cost	0	10, 985, 724	1.00
2.00	Hospi tal		0	10, 985, 724	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0167 Period: From 10/07/201 To 12/31/2010 Worksheet S-1 bate/Time Pre Solution Incompensated and indigent care cost computation 1.00 Incompensated and costs for Wedicaid Program (Line 7 minus sum of lines 2 and 5: if f.1749.45 1.749.45 Incompensated cost (Line 1 times line 10) 1.00 1.00 Incompensated or local program (CHP) cose instructions for each line) 0.00 Intervene from stand-alone CHP 0.00 <							
To 12/31/2019 Date/Time Pre 6/23/2020 1: 6/23/2020 1/23/2020 1: 6/23/2020 1/23/2020 1/23/2020 1/23/2020 1/23/2020 1/23/2020 1/23/2020 1/23/2020 1/23/2020 1/							
Incompensated and indigent care cost computation 1.00 Cost to charge ratio. (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.168742 2.00 Net revenue from Medicaid 73.621 2.00 Net revenue from Medicaid 73.621 2.00 If line 4 is no, then entre DSH and/or supplemental payments from Medicaid 73.621 2.00 Medicaid cost (line 1 times line 6) 10.803.927 3.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if < zero then enter zero)							
Uncompensated and indigent care cost computation Image: cost compares and indigent care cost computation 1.00 Cost to charge ratio. (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.168742 2.00 Net revenue from Medicaid 73.621 2.00 Net revenue from Medicaid 73.621 2.00 Net revenue from Medicaid 73.621 3.00 Did you receive DSH or supplemental payments from Medicaid? 11.00 5.01 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 73.621 6.00 Medicaid cost (line 1 times line 6) 10.803.927 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if c zero then enter zero) 1,749,455 Children's Health Insurance Program (CHIP) (see instructions for each line) 0 0 10.00 Stand-alone CHIP cost (line 1 times line 10) 0 0 0 11.00 Stand-alone CHIP cost (line 1 times line 10) 0 0 0 0 12.00 Difference between net revenue and costs for state or local indigent care program (Not included on lines 2, 5 or 9) 5, 749,986 0 0 0 0							
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.168742 Medicaid (see instructions for each line) 73,621 2.00 Net revenue from Medicaid 73,621 3.00 Did you receive DSH or supplemental payments from Medicaid? 73,621 5.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 0 6.00 Medicaid cost (line 1 times line 6) 10,803,927 7.00 Medicaid cost (line 1 times line 6) 10,803,927 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if 1,749,455 < zero then enter zero)							
Medicaid (see instructions for each line) 73,621 00 Net revenue from Medicaid 73,621 3:00 Did you receive DSH or supplemental payments from Medicaid? 11 line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 73,621 3:00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 00 00 6:00 Medicaid charges 10,803,927 18,823,076 0:00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,749,455 1,749,455 c. Zor then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 00 0:00 Stand-al one CHIP cost (line 1 times line 10) 00 00 0:00 Stand-al one CHIP cost (line 1 times line 10) 00 00 0:00 Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero)							
3.00 Did you receive DSH or supplemental payments from Medicaid? 0 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 0 6.00 Medicaid charges 0 7.00 Medicaid cost (line 1 times line 6) 10,803,927 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,749,455 c. zor then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 0 9.00 Net revenue from stand-alone CHIP 0 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0 0.01 Other state or local indigent care program (Net included on lines 2, 5 or 9) 5,749,966 11.00 State or local indigent care program (Not included on lines 2, 5 or 9) 5,749,966 12.00 Difference between net revenue and costs for state or local indigent care program (Not included on lines 2, 5 or 9) 5,749,966 13.00 Charges for patients covered under state or local indigent care program (Not included on lines 2, 5 or 9) 5,749,966 14.00 Greants, donations, or endowment income restricted to funding charity care 0 10.00 Freence between net revenue and costs for state or local indi							
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 00 5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 00 6.00 Medicaid charges 10,803,927 7.00 Medicaid cost (line 1 times line 6) 11,823,076 7.00 Medicaid cost (line 1 times line 6) 11,749,455 7.00 Net revenue row stand-al one CHIP (see instructions for each line) 11,749,455 9.00 Stand-al one CHIP cost (line 1 times line 10) 00 01 0.00 Stand-al one CHIP cost (line 1 times line 10) 00 00 0.10.00 Stand-al one CHIP cost (line 1 times line 10) 00 00 0.10.00 State or local government indigent care program (see instructions for each line) 00 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 5,749,986 16.00 Difference between net revenue and costs for state or local indigent care program (Not included on lines 2, 5 or 9) 5,108,676 15.00 State or local indigent care program cost (line 1 times line 14) 5,108,676 16.00 Difference between net revenue and costs for Medicaid. CHIP and state/local indigent care programs (see instructions for each line) </td							
5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 0 6.00 Medicaid charges 10,803,927 7.00 Medicaid cost (line 1 times line 6) 11,749,455 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if f 1,749,455 c. zor then enter zero) Children's Health Insurance Program (CHIP) (see instructions for each line) 0 9.00 Net revenue from stand-alone CHIP 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 11.00 Stand-alone CHIP cost (line 1 times line 10) 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
6.00 Medicaid charges 10,803,927 7.00 Medicaid cost (line 1 times line 6) 1,749,455 0.01 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,749,455 0.02 Children's Health Insurance Program (CHIP) (see instructions for each line) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
7.00 Medicaid cost (line 1 times line 6) 1, 823, 076 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1, 749, 455 < zoro then enter zero)							
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,749,455 0.01 Children's Health Insurance Program (CHIP) (see instructions for each line) 0 9.00 Net revenue from stand-alone CHIP 0 0.00 Stand-alone CHIP cost (line 1 times line 10) 0 0.10 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
< zero then enter zero)							
9.00 Net revenue from stand-al one CHLP 0.00 10.00 Stand-al one CHLP charges 0.00 11.00 Stand-al one CHLP cost (line 1 times line 10) 0.00 12.00 Difference between net revenue and costs for stand-al one CHLP (line 11 minus line 9; if < zero then enter zero)							
10.00 Stand-al one CHIP charges 0 11.00 Stand-al one CHIP cost (line 1 times line 10) 0 12.00 Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero)							
11.00 Stand-alone CHIP cost (line 1 times line 10) 0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then							
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 5,749,986 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 30,275,072 15.00 State or local indigent care program cost (line 1 times line 14) 5,108,676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13) 5,108,676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13) 5,108,676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13) 5,108,676 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 1, 749,455 1, 749,455 19.00 Uninsured Insured Insured Insured Insured patients patients + col. 2) 1.00 2.00 3.00 19.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 0 0 0 0 0							
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 5,749,986 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 30,275,072 15.00 State or local indigent care program cost (line 1 times line 14) 5,108,676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)							
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 30,275,072 15.00 State or local indigent care program cost (line 1 times line 14) 5,108,676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)							
10) State or local indigent care program cost (line 1 times line 14) 5, 108, 676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 5, 108, 676 13: if < zero then enter zero)							
15.00 State or local indigent care program cost (line 1 times line 14) 5, 108, 676 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line) 5 13: if < zero then enter zero)							
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 0 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 13, 12 and 16) 0 18.00 Government grants, appropriations or transfers for support of hospital operations 8, 12 and 16) 1, 749, 455 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Total (col. 1 + col. 2) 10.00 2.00 3.00 10.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 448, 632 582, 522 1, 031, 154 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 75, 703 582, 522 658, 225 22.00 Payments received from patients for amounts previously written off as 0 0 0							
13: if < zero then enter zero)							
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1,749,455 19.00 Uninsured cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1,749,455 20.00 Uncompensated Care (see instructions for each line) Uninsured patients 1 + col. 2) 10.00 2.00 3.00 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 448,632 582,522 1,031,154 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 75,703 582,522 658,225 22.00 Payments received from patients for amounts previously written off as 0 0 0							
17.00 Private grants, donations, or endowment income restricted to funding charity care 00 18.00 Government grants, appropriations or transfers for support of hospital operations 01 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines at a patients at a patients) 1,749,455 19.00 Uninsured cost for Medicaid, CHIP and state and local indigent care programs (sum of lines at a patients) Total (col. 1 + col. 2) 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 3.00 10.00 2.00 582,522 10.01,154							
19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1,749,455 2,1749,456 2,1749,456 2,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,456 2,1759,1749,1749,456 2,1759,1749,1749,1749,1749,1749,1749,1749,174							
B, 12 and 16) Uninsured patients Insured patients Total (col. 1 + col. 2) Uncompensated Care (see instructions for each line) 1.00 2.00 3.00 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 448, 632 582, 522 1, 031, 154 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 75, 703 582, 522 658, 225 22.00 Payments received from patients for amounts previously written off as 0 0 0							
Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Total (col. 1 + col. 2) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 448,632 582,522 1,031,154 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 75,703 582,522 658,225 22.00 Payments received from patients for amounts previously written off as 0 0 0							
Uncompensated Care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility20.00Charity care charges and uninsured discounts for the entire facility20.00Cost of patients approved for charity care and uninsured discounts (see21.00Cost of patients approved for charity care and uninsured discounts (see22.00Payments received from patients for amounts previously written off as00							
Uncompensated Care (see instructions for each line)20.00Charity care charges and uninsured discounts for the entire facility (see instructions)448,632 582,522582,52221.00Cost of patients approved for charity care and uninsured discounts (see instructions)75,703 582,522582,52222.00Payments received from patients for amounts previously written off as00							
20.00Charity care charges and uninsured discounts for the entire facility448,632582,5221,031,154(see instructions)21.0021.00cost of patients approved for charity care and uninsured discounts (see75,703582,522658,225instructions)22.00Payments received from patients for amounts previously written off as00							
21.00Cost of patients approved for charity care and uninsured discounts (see instructions)75,703582,522658,22522.00Payments received from patients for amounts previously written off as000							
instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0							
charity care							
23.00 Cost of charity care (line 21 minus line 22) 75,703 582,522 658,225							
1.00							
4.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N							
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 length of 0 stay limit							
26.00 Total bad debt expense for the entire hospital complex (see instructions) 1,474,116							
27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 53,292							
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)53,29228.00Non-Medicare bad debt expense (see instructions)1,420,824							
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)53,29228.00Non-Medicare bad debt expense (see instructions)1,420,82429.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)258,405							
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)53,29228.00Non-Medicare bad debt expense (see instructions)1,420,824							

FCLASSIE	nancial Systems Of ICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	RTHOPAEDIC HOSPT	Provi der C	CN· 15-0167	Peri od:	eu of Form CMS-2 Worksheet A	2552-
_0LA3511	TOATION AND ADJUSTMENTS OF TRIAE DREANCE OF	EXTENSES			From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassificati	Recl assi fi ed	-
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2 00	2 00	4.00	<u>col. 4)</u> 5.00	
GEN	INERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	100 CAP REL COSTS-BLDG & FIXT		2, 198, 104	2, 198, 10	4 -967, 127	1, 230, 977	1 1.
	200 CAP REL COSTS-MVBLE EQUIP		0		0 967, 127		
. 00 003	300 OTHER CAP REL COSTS		0		0 0	0	3.
. 00 004	400 EMPLOYEE BENEFITS DEPARTMENT	1, 515, 810	4, 475, 831	5, 991, 64	1 -1, 515, 810	4, 475, 831	4.
. 00 005	500 ADMINISTRATIVE & GENERAL	1, 015, 878	16, 432, 434	17, 448, 31	2 853, 195	18, 301, 507	5.
. 00 007	700 OPERATION OF PLANT	0	650, 306	650, 30	6 0	650, 306	7.
. 00 008	BOO LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.
. 00 009	900 HOUSEKEEPI NG	246, 614	285, 677	532, 29	1 15, 444	547, 735	9.
0.00 010	DOO DI ETARY	0	192, 953	192, 95	3 0	192, 953	10.
1.00 011	100 CAFETERI A	0	0		0 0	0	11.
2.00 012	200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.
3.00 013	300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	13.
	400 CENTRAL SERVICES & SUPPLY	0	29, 727	29, 72	7 0	29, 727	14.
	500 PHARMACY	0	2, 390	2, 39	0 0	2, 390	15.
6.00 016	600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.
7.00 017	700 SOCIAL SERVICE	259, 834	193	260, 02	7 16, 272	276, 299	17.
9.00 019	900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	19.
0.00 020	DOO NURSING SCHOOL	0	0		0 0	0	20.
1.00 021	100 I & R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.
2.00 022	200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.
	300 PARAMED ED PRGM	0	0		0 0	0	23.
	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDI ATRI CS	2, 699, 074	473, 686	3, 172, 76	0 101, 682	3, 274, 442	30.
	CILLARY SERVICE COST CENTERS						
	DOO OPERATING ROOM	6, 046, 082	34, 088, 187				
	300 ANESTHESI OLOGY	120, 779	538				
	400 RADI OLOGY-DI AGNOSTI C	0	86, 013			,	
	BOO MRI	476, 291	258, 980				
	DOO LABORATORY	0	333, 528				
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	44 74	0 0	0	
	500 RESPI RATORY THERAPY	000 170	41, 714				
	600 PHYSI CAL THERAPY	893, 172	24, 976				
	900 ELECTROCARDI OLOGY	0	223				
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 629, 736		
2.00 072	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	(2, 105	0 101 500	2 104 / 2	0 23, 913, 250		
		63, 125	2, 121, 503	2, 184, 62			
	697 CARDI AC REHABI LI TATI ON	0	0		0 0		
	698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	-	
	699 LITHOTRIPSY IPATIENT SERVICE COST CENTERS	0	0	I	0 0	0	1 /0.
	DOO CLINIC	0	0		0 0	0	90.
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	90.
	ECIAL PURPOSE COST CENTERS			I		l	72.
SPE	500 AMBULATORY SURGICAL CENTER (D. P.)	3, 564, 560	8, 325, 573	11, 890, 13	3 0	11, 890, 133	115
15 00 115		16, 901, 219	70, 022, 536				
	SUBIDIALS (SUM OF LINES I Through 117)					00,700,271	1110.
18. 00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 901, 219	70,022,000				
18.00 NON	SUBIOTALS (SUM OF LINES I THROUGH III) NREIMBURSABLE COST CENTERS 951 PHYS THERAPY PERFORMANCE CENTER	7, 548, 721	7, 232, 448			1	

ECLASSI FI CAT	ION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet Date/Time 6/23/2020	Prepare
C	ost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	1	- I	072372020	1.20 pm
CENEDAL	SERVICE COST CENTERS	6.00	7.00				
	AP REL COSTS-BLDG & FIXT	0	1, 230, 977				1.
	AP REL COSTS-BEDG & TTXT						2.
		-		1			
	THER CAP REL COSTS	0	-				3.
	MPLOYEE BENEFITS DEPARTMENT	-690, 902					4.
	DMINISTRATIVE & GENERAL	4, 853, 504					5.
	PERATION OF PLANT	C	650, 306				7.
	AUNDRY & LINEN SERVICE	0	۰ ۱				8.
	OUSEKEEPING	0					9.
0.00 01000 D		0	192, 953				10.
1.00 01100 C	AFETERIA	0	0				11.
2.00 01200 M	AINTENANCE OF PERSONNEL	C					12.
3.00 01300 N	URSING ADMINISTRATION	C					13.
4.00 01400 C	ENTRAL SERVICES & SUPPLY	0	29, 727				14.
5.00 01500 P	HARMACY	0	2, 390				15.
	EDICAL RECORDS & LIBRARY						16.
	OCIAL SERVICE		276, 299	,			17.
	ONPHYSICIAN ANESTHETISTS						19.
	URSI NG SCHOOL						20.
	&R SERVICES-SALARY & FRINGES APPRV						21.
	&R SERVICES-OTHER PRGM COSTS APPRV		-				22.
1 1			-				
	ARAMED ED PRGM NT ROUTINE SERVICE COST CENTERS		ν _μ υ υ	1			23.
	DULTS & PEDIATRICS	2,630	3, 277, 072				30.
	RY SERVICE COST CENTERS	2,030	5,211,012	·]			50.
	PERATING ROOM	-34	11, 647, 842				50.
	NESTHESI OLOGY	-34					53.
				1			
	ADI OLOGY-DI AGNOSTI C		00,010	1			54.
8.00 05800 M			760, 369				58.
	ABORATORY		333, 528	1			60.
	HOLE BLOOD & PACKED RED BLOOD CELL		0	1			62.
	LOOD CLOTTING FOR HEMOPHILIACS		0	1			62.
	ESPI RATORY THERAPY		41, 714	1			65.
	HYSI CAL THERAPY	0	974, 083	•			66.
	LECTROCARDI OLOGY	C	223				69.
	EDICAL SUPPLIES CHARGED TO PATIENT	0	4, 629, 736				71.
	MPL. DEV. CHARGED TO PATIENTS	C	20, 7.0, 200	1			72.
	RUGS CHARGED TO PATIENTS	0	2, 188, 582				73.
	ARDIAC REHABILITATION	C	0				76.
	YPERBARIC OXYGEN THERAPY	0	-	•			76.
6.99 07699 L	I THOTRI PSY	0	0				76.
	ENT SERVICE COST CENTERS						
0. 00 09000 C		C	0				90.
2.00 09200 0	BSERVATION BEDS (NON-DISTINCT PART						92.
	PURPOSE COST CENTERS			•			
	MBULATORY SURGICAL CENTER (D. P.)	513, 708	12, 403, 841				115.
	UBTOTALS (SUM OF LINES 1 through 117)	4, 678, 906		•			118
	BURSABLE COST CENTERS	., ., ., ., .,	, 6.6, 177				
	HYS THERAPY PERFORMANCE CENTER	1, 849, 868	16, 618, 501				194.
	OTAL (SUM OF LINES 118 through 199)	6, 528, 774					200

ASSI	FICATIONS			Provider CCN:	From 01/01/20	
					To 12/31/20	
		Increases				
	Cost Center	Line #	Salary	Other		
•	2.00 - BUI LDI NG DEPRECI ATON	3.00	4.00	5.00		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	967, 127		1.
0	N REL COSTS-MVBLE EQUIP	2.00		967, 127		1.
	B - MED AND IV SUPPLIES					
	IEDI CAL SUPPLI ES CHARGED TO	71.00	0	28, 542, 986		1.
ľ		0.00	О	0		2.
		0.00	0	0		3.
0			0	28, 542, 986		
	C - TELEPHONE EXPENSE	5.00	0	14 040		1
A	DMINISTRATIVE & GENERAL		0	14, 049		1.
0			0			2.
-) - PTO PALD		V_	14, 047		
	INDI NI STRATI VE & GENERAL	5.00	23, 636	0		1.
	IOUSEKEEPI NG	9.00	5, 738	Ő		2.
	SOCIAL SERVICE	17.00	6, 045	0		3.
A	DULTS & PEDIATRICS	30.00	62, 798	0		4.
	PERATING ROOM	50.00	140, 671	0		5.
	NESTHESI OLOGY	53.00	2, 810	0		6.
		58.00	11, 082	0		7.
	PHYSICAL THERAPY	66.00 73.00	20, 781	0		8.
D	DRUGS_CHARGED_TO_PATIENTS		<u>1, 4</u> 69 275, 030	— — <u>0</u>		9.
F	– PTO EARNED		275,050	0		
	DMI NI STRATI VE & GENERAL	5.00	39, 984	0		1.
н	IOUSEKEEPI NG	9.00	9, 706	0		2.
S	SOCIAL SERVICE	17.00	10, 227	0		3.
	DULTS & PEDIATRICS	30.00	106, 232	0		4.
	PERATING ROOM	50.00	237, 966	0		5.
	NESTHESI OLOGY	53.00	4, 754	0		6.
		58.00	18, 746	0		7.
	PHYSICAL THERAPY DRUGS CHARGED TO PATIENTS	66.00 73.00	35, 154 2, 485	0		8.
0			465, 254	<u>0</u>		9.
F	- HOME OFFICE					
A	DMI NI STRATI VE & GENERAL	5.00	7, 204, 458	0		1.
	MBULATORY SURGICAL CENTER	115.00	1, 141, 648	0		2.
	D. P.) PHYS THERAPY PERFORMANCE	194.00	1, 419, 234	0		3.
	ENTER	174.00	1, 417, 234	0		5.
0)	+	9, 765, 340	— — <u></u>		
	I - PURCHASED SERVICES					
	DMINISTRATIVE & GENERAL	5.00	938, 329	0		1.
	PERATION OF PLANT	7.00	152, 152	0		2.
	IOUSEKEEPI NG	9.00	64, 324	0		3.
	DI ETARY CENTRAL SERVICES & SUPPLY	10.00	192, 953	0		4.
	PHARMACY	14.00 15.00	29, 727 2, 390	0		5.
	DULTS & PEDIATRICS	30.00	2, 390 5, 717	0		
	PERATING ROOM	50.00	1,047,401	0		8.
	ADI OLOGY-DI AGNOSTI C	54.00	86, 013	õ		9.
	ABORATORY	60.00	333, 528	0		10.
	ESPI RATORY THERAPY	65.00	39, 765	0		11.
οÞ	RUGS_CHARGED_TO_PATIENTS	73.00	642, 326	0		12.
0			3, 534, 625	0		
	- I MPLANTS MPL. DEV. CHARGED TO	72.00	0	23, 913, 250		1.
	PATIENTS	72.00	U	23, 713, 230		1.
Ō)	+	0	23, 913, 250		
	- ANESTHESI A					
A	NESTHESI OLOGY	53.00	0	<u>392, 6</u> 09		1.
0			0	392, 609		
	- BONUS DOLLARS RECLASS	E OO	775 524			1.
A	<u>DMI NI STRATI VE & GENERAL</u>	5.00	<u>775, 526</u> 775, 526	— — — <u>0</u>		1.
μ	irand Total: Increases		14, 815, 775	53, 830, 021		500.

	nancial Systems	0	RTHOPAEDI C HOSP		CCN: 15-0167	Peri od:	u of Form CMS-2552- Worksheet A-6
02.0011						From 01/01/2019 To 12/31/2019	Date/Time Prepared
		Decreases					6/23/2020 1:28 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	-	
A	- BUILDING DEPRECIATON						
00 CA	AP_REL_COSTS_BLDG_&_FIXT	1.00	0	967, 127		9	1. (
0			0	967, 127	r		
	- MED AND IV SUPPLIES					- 1	
	DULTS & PEDIATRICS	30.00	0	67, 348		o	1. (
	PERATING ROOM	50.00	0	28, 470, 908		o	2.0
00 <u>MR</u>	<u> </u>	<u>58.</u> 00	0	4,730		익	3. (
0			0	28, 542, 986			
	- TELEPHONE EXPENSE	F0.00	0	1 510	, I	o	1 (
	IYS THERAPY PERFORMANCE	50.00 194.00	0	1, 513 12, 536		0	1. (
	ENTER	194.00	0	12, 550		0	2.0
0		+		14,049	,	-	
D	- PTO PAID			11,017			
	APLOYEE BENEFITS DEPARTMENT	4.00	275, 030	C)	0	1. (
00		0.00	0	C		0	2.0
00		0.00	0	C)	o	3. (
00		0.00	o	C)	o	4. (
00		0.00	0	C)	o	5. (
00		0.00	0	C)	o	6. (
00		0.00	0	C		o	7. (
00		0.00	0	C		0	8. (
00		0.00			<u> </u>	익	9. (
0			275, 030	C)		
	- PTO EARNED	4.00	445 254	C	<u></u>	o	1.0
00 EN 00	IPLOYEE BENEFITS DEPARTMENT	0.00	465, 254 0	C		0	1. (
00		0.00	0	C		0	3. (
00		0.00	0	0		0	4. (
00		0.00	0	C		0	5.0
00		0.00	o	C		o	6. 0
00		0.00	0	C)	0	7. (
00		0.00	0	C)	o	8. (
00		0.00	0	C)	o	9. (
0			465, 254	C)		
	- HOME OFFICE						
	OMINISTRATIVE & GENERAL	5.00	0	7, 204, 458		0	1. (
	MBULATORY SURGI CAL CENTER	115.00	0	1, 141, 648	8	0	2.0
		104.00		1 410 004			
	HYS THERAPY PERFORMANCE	194.00	0	1, 419, 234	+	0	3. (
		+		9, 765, 340	<u> </u>	-	
н	- PURCHASED SERVICES		<u> </u>	7, 705, 540	/		
	DMINISTRATIVE & GENERAL	5.00	0	938, 329		0	1. (
	PERATION OF PLANT	7.00	0	152, 152		0	2.0
	DUSEKEEPI NG	9.00	0	64, 324		0	3. (
	ETARY	10.00	0	192, 953		o	4. (
00 CE	ENTRAL SERVICES & SUPPLY	14.00	o	29, 727	,	o	5.0
00 PH	IARMACY	15.00	0	2, 390)	o	6. (
	DULTS & PEDIATRICS	30.00	0	5, 717	r	o	7. (
	PERATING ROOM	50.00	0	1, 047, 401		o	8. (
	ADI OLOGY-DI AGNOSTI C	54.00	0	86, 013		0	9. (
	ABORATORY	60.00	0	333, 528		0	10. (
	SPIRATORY THERAPY	65.00	0	39, 765		0	11. (
. 00 DR	RUGS_CHARGED_TO_PATIENTS	73.00	•	642, 326		<u>u</u>	12. (
0			0	3, 534, 625			
	- IMPLANTS EDICAL SUPPLIES CHARGED TO	71.00	0	23, 913, 250		0	1. (
	ATIENT	71.00	0	23, 713, 230			1.0
0	·········	+	— — — d	23, 913, 250)	1	
J	- ANESTHESI A		<u> </u>			1	
	PERATING ROOM	50.00	0	392, 609)	0	1. (
0			0	392, 609		7	
L	- BONUS DOLLARS RECLASS	1	-1			•	
	MPLOYEE BENEFITS DEPARTMENT	4.00	775, 526	C)	0	1. (
0			775, 526	C)	_	
-	rand Total: Decreases		1, 515, 810	67, 129, 986			500.0

Heal th	Financial Systems C	RTHOPAEDI C HOSF	PT. AT PARKVI EW			ln Li€	eu of Form CMS-:	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider C				Worksheet A-7 Part I	pared:
				Acquisition				
		Begi nni ng Bal ances	Purchases	Donati on	To	tal	Disposals and Retirements	
		1.00	2.00	3.00	4.	00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00 2.00	Land Land Improvements	0	0 0		0	0	0	1.00 2.00
3.00	Buildings and Fixtures	9, 446, 043	0		0	0	0	3.00
4.00	Building Improvements	6, 304, 390	578, 548		0	578, 548	0	4.00
5.00	Fixed Equipment	8, 786, 262	0		0	0	0	5.00
6.00	Movable Equipment	9, 884, 947	9, 397, 287		0 9,	397, 287	2, 073, 697	6.00
7.00	HIT designated Assets	3, 511, 182	169, 448		0	169, 448		7.00
8.00	Subtotal (sum of lines 1-7)	37, 932, 824	10, 145, 283		0 10,	145, 283	2, 073, 697	8.00
9.00	Reconciling Items	-2, 690, 934	-24, 489		0	-24, 489	-2, 189, 496	9.00
10.00	Total (line 8 minus line 9)	40, 623, 758	10, 169, 772		0 10	169, 772	4, 263, 193	10.00
		Ending Balance	Fully					
		Ű	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	9, 446, 043	765, 352					3.00
4.00	Building Improvements	6, 882, 938	830, 506					4.00
5.00	Fixed Equipment	8, 786, 262	44, 171					5.00
6.00	Movable Equipment	17, 208, 537	6, 728, 801					6.00
7.00	HIT designated Assets	3, 680, 630	0					7.00
8.00	Subtotal (sum of lines 1-7)	46, 004, 410	8, 368, 830					8.00
9.00	Reconciling Items	-525, 927	0					9.00
10.00	Total (line 8 minus line 9)	46, 530, 337	8, 368, 830					10.00

Heal th	Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lieu of Form CMS-		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0167	Period:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		narod
					10 12/31/2017	6/23/2020 1:2	
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 198, 104	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 198, 104	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 198, 104				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 198, 104				3.00

Health Financial Systems C	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 Fo 12/31/2019	Worksheet A-7 Part III Date/Time Prep 6/23/2020 1:28	
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3,00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	25, 115, 243	0	25, 115, 243	0. 593407	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	17, 208, 537	0	17, 208, 537	0. 406593	0	2.00
3.00 Total (sum of lines 1-2)	42, 323, 780		42, 323, 780		0	3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	-			-	
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(1, 230, 977	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(967, 127	0	2.00
3.00 Total (sum of lines 1-2)	0	0		2, 198, 104	0	3.00
		SU	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	-				1 000 077	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	1, 230, 977	1.00 2.00
3.00 Total (sum of lines 1-2)	0				967, 127	2.00
3.00 TOLAT (SUIII OF TITLES T-2)	1 0	1 0	1 (ט וי	2, 198, 104	3.00

nancial Systems OR	RTH
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ΤΗΩΡΔΕDIC ΗΩSPT ΔΤ ΡΔΡΚVIEW

ADJUST	Financial Systems MENTS TO EXPENSES			PT. AT PARKVIEW Provider CCN: 15-0167	Period:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/23/2020 1:23	
				Expense Classification of To/From Which the Amount is		0/23/2020 1.20	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	4.00	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
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	
3.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	8, 662, 894			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0 0		0.00 0.00	0	
15.00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16. OC
17.00	patients Sale of drugs to other than patients		0		0.00	0	17.00
8.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25. 00	physicians' compensation		0	*** Cost Center Deleted ***	* 114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	*** Cost Center Deleted ***	0.00 67.00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest OTHER OPERATING REVENUE	В	-19, 114	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems	O	RTHOPAEDI C HOSE	PT. AT PARKVI EW	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						6/23/2020 1:2	8 pm
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	oust benter beschiption	1.00	2.00	3.00	4,00	5.00	
34.00	OTHER OPERATING REVENUE	В		AMBULATORY SURGICAL CENTER	115.00		34.00
				(D. P.)			
35.00	SELF INSURANCE OFFSET	A	-690, 902	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	35.00
36.00	NON ALLOWABLE LOBBY EXPENSE	A	-5, 807	ADMI NI STRATI VE & GENERAL	5.00	0	36.00
37.00	TELEMETRY	A	2, 630	ADULTS & PEDIATRICS	30.00	0	37.00
40.00	NON ALLOWABLE LOBBY EXPENSES	A	-34	OPERATING ROOM	50.00	0	40.00
41.00	NON ALLOWABLE LOBBY EXPENSES	A	-625	AMBULATORY SURGICAL CENTER	115.00	0	41.00
				(D. P.)			
42.00	PHYSICIAN ADMINISTRATION	A	213, 349	ADMINISTRATIVE & GENERAL	5.00	0	42.00
	ADD-BACK						
43.00	REMOVE HAF TAX	A	-1, 627, 660	ADMINISTRATIVE & GENERAL	5.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49)		6, 528, 774				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form C						
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0167	Period:	Worksheet A-8	8-1
OFFICE COSTS				From 01/01/2019 To 12/31/2019		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	14, 082, 802	7, 790, 066	1.00
2.00	115.00	AMBULATORY SURGICAL CENTER (HOME OFFICE COST REPORT	2, 231, 618	1, 711, 328	2.00
3.00	194.00	PHYS THERAPY PERFORMANCE CEN	HOME OFFICE COST REPORT	2, 774, 226	924, 358	3.00
4.00	0.00		HOME OFFICE COST REPORT	0	0	4.00
5.00	TOTALS (sum of lines 1-4).			19, 088, 646	10, 425, 752	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

110	been posted to worksheet A,	corumns r anu/or z, the amount			or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B INTERPRIATIONSHIP TO RELAT	TED OPCANIZATION(S) AND/OP HO				

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.

1 of model			
6.00	В	0.00 PARKVI EW HEALTH SYSTEM, I NC 60.00	6.00
7.00	В	0.00 NORTHEAST ORTHOPAEDIC 40.00	7.00
		HOSPITAL INVE	
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		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.

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PAR	RKVLEW	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED OFFICE COSTS	ORGANIZATIONS AND HOME Provi		riod: Workshee om 01/01/2019 12/31/2019 Date/Tim 6/23/2020		
Net Wkst A-7 Ref					

		Net	Wkst. A-7 Ref.		
		Adjustments			
		(col. 4 minus			
		col. 5)*			
		6.00	7.00		
		A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
		HOME OFFICE CO	STS:		
1.0	0	6, 292, 736	0		1.00
2.0	0	520, 290	0		2.00
3.0	0	1, 849, 868	0		3.00
4.0	0	0	0		4.00
5.0	0	8, 662, 894			5.00

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

1143	not been posted to worksheet A,		the amount	arrowable should	be mulcated m	tin s part.	
	Related Organization(s)						
	and/or Home Office						
	Type of Business						
	6.00]					
	B. INTERRELATIONSHIP TO RELAT	TED 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 . roimburcomont under title VVIII

reriibui									
6.00	HEALTH SYSTEM	6.00							
7.00	ORTHOPAEDI C SERVI CES	7.00							
8.00		8.00							
9.00		9.00							
10.00		10.00							
100.00		100.00							

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

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

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

CDST_ALIOLATION CRIMINAL SERVICE COSTS Providee CDE Is of the Providee CDE	Heal th Financial	Systems 0	RTHOPAEDI C HOSF	PT. AT PARKVLEW		In Lie	u of Form CMS-:	2552-10
To 12/31/2017 Distort Time Progenet: DV2/2020 1-28 pm BL/0 6 F1XT European BL/0 6 F1XT Subtort European BL/0 6 F1XT Subtort F1XT European BL/0 6 F1XT European BL/0 F						eri od:	Worksheet B	2002 10
Cost Center Description Net Expanse CAPI TAL RELATED COSTS PARLOYEE CAPI TAL RELATED COSTS In one Cost Al location BLG6 & FLXT MVBLE EQUIP BLBC6 & FLXT BUBC & FLXT Subtotal 1 000 Cost Control BLD6 & FLXT MVBLE EQUIP BLBC6 & FLXT BLBC6 & FLXT BLBC6 & FLXT Subtotal 1 000 Cost Control Cost Control 1.00 2.00 4.00 4A 1 000 Cost Control Subtotal FLXT Subtotal FLXT Subtotal FLXT 0 00 000 CAP FEL COSTS-BLD0 & FLXT 1.230,977 9.67,127 0.784,792 1.00 2.00 4.00 4.00 1 000 000 CAP FEL COSTS-BLD0 & FLXT StXT StXT 0.0 3.784,929 0.0 3.784,929 2.00 0.0								narod
Cost Center Description Not Expenses For Cost (Crost Wink 2) BUG 6 FIXT WBLE EQUIP EMPLOYEE BEFARTNERS Subtotal 0 Ontool CAP 200 Cost Center Description 1.00 2.00 4.00 44 1.00 Ontool CAP 200 Description 1.230, 977 1.230, 977 1.230, 977 1.00 2.00 4.00 4.00 2.00 Description 1.00, 2.00 4.00 4.00 4.00 4.00 2.00 00200 (CAP REL COSTS-MUNEL EQUIP 997, 127 1.230, 977 1.230, 977 1.00, 2.00 3.7,84, 929 4.00 4.00 0.00000 (LAINDRY & LINEN SERVICE 650, 30, 01 282, 20 3.47,96 1.00, 2.420 4.00, 0 1.00 0.00000 (LAINDRY & LINEN SERVICE 547,735 0 0.2,724 580, 650, 90 1.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 12/31/2019</td> <td></td> <td></td>						0 12/31/2019		
For Cost (From Wist) A For Cost (From Wist) A BEWEFITS D BEWEFITS DEPARTMENT 0 0.0000 (AP FEL COSTS CENTERS 0 4.00 4A 1.00 0.0000 (AP FEL COSTS MORE & EQUIP 0.0000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP NET) (AP CAST 0.000000 (AP NET) (AP CAST 0.00000 (AP CAST 0.000000 (AP CAST 0.00000 (AP CAST 0.000000 (AP CAST 0.000000 (AP CAST 0.0000000 (AP CAST 0.00000000000 (AP CAST 0.00000000000000000000000000000000000				CAPI TAL REL	ATED COSTS			
For Cost (From Wist) A For Cost (From Wist) A BEWEFITS D BEWEFITS DEPARTMENT 0 0.0000 (AP FEL COSTS CENTERS 0 4.00 4A 1.00 0.0000 (AP FEL COSTS MORE & EQUIP 0.0000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP REL COSTS-MURLE EQUIP 0.00000 (AP NET) (AP CAST 0.000000 (AP NET) (AP CAST 0.00000 (AP CAST 0.000000 (AP CAST 0.00000 (AP CAST 0.000000 (AP CAST 0.000000 (AP CAST 0.0000000 (AP CAST 0.00000000000 (AP CAST 0.00000000000000000000000000000000000								
Line DEPARTMENT DEPARTMENT 100 Coll 7) 0 1.00 2.00 4.00 4.0 100 COLL CAP ELL COSTS -BLUE A, FLXT 1.230, 977 967, 127 2.00 2.00 0.00 COLL CAP ELL COSTS -BUBLE A, FLXT 1.230, 977 967, 127 2.00 4.00 4.00 0.00 COLL CAP ELL COSTS -BUBLE A, FLXT 1.230, 977 967, 127 2.00 4.00 0.00 COLL CAP ELL COSTS -BUBLE A, FLXT 1.230, 977 967, 127 4.00 4.00 4.00 0.00 COLL CAP ELL COSTS -BUBLE A, FLXT 2.3, 155, 01 22.02 3.784, 929 4.00 0.00 <td>Cos</td> <td>t Center Description</td> <td></td> <td>BLDG & FIXI</td> <td>MARTE EOOLA</td> <td></td> <td>Subtotal</td> <td></td>	Cos	t Center Description		BLDG & FIXI	MARTE EOOLA		Subtotal	
Line Line <thline< th=""> Line Line <thl< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thl<></thline<>								
Col. 7)								
EKERAL SERVICE COST CENTERS								
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2.00 00200 CAP. REL. COSTS-WIELE COULP 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 997, 127 1,002, 420 24, 474, 430 5,00 0.00 000000 DEEATION OF PLANT 650, 306 0 317, 654 15, 255 998, 215 7, 00 0700 000 0 <t< td=""><td></td><td></td><td></td><td></td><td>1</td><td>1</td><td></td><td></td></t<>					1	1		
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15.00 PLARMACY 2,390 0 0 240 2,630 15.00 16.00 1000 NECORDS & LIBRARY 0 0 0 0 16.00 16.00 17.00 01700 SCIAL <service< td=""> 276,299 0 0 27,683 303,962 17,00 19.00 01900 NURSING SCHOOL 0 0 0 0 0 0 27,683 303,962 17,00 20.00 02000 NURSING SCHOOL 0 0 0 0 0 0 0 21.00 22.00 23.04 43.54 53.55.3664 288,138 3.965.543 30.00 55.05.05.05.05.05.05.05.05.05.05.05.05.0</service<>			0	0	C	-		
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20. 00 00 0 </td <td></td> <td></td> <td>210, 299</td> <td>0</td> <td></td> <td>27,083</td> <td></td> <td></td>			210, 299	0		27,083		
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115.00 AMBULATORY SURGICAL CENTER (D. P.) 12,403,841 0 191,220 471,859 13,066,920 115.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 91,615,197 1,230,977 845,141 2,885,775 90,594,057 118.00 NONREL MBURSABLE COST CENTERS 194.00 07951 PHYS THERAPY PERFORMANCE CENTER 16,618,501 0 121,986 899,154 17,639,641 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			<u> </u>		I		0	72.00
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201.00 Negative Cost Centers 0 0 0 0 0 201.00			16, 618, 501	0	121, 986	899, 154		
202.00 101AL (sum lines 118 through 201) 108,233,698 1,230,977 967,127 3,784,929 108,233,698 202.00			100	0				
	202.00 101	AL (SUM LINES LINE THROUGH 201)	108, 233, 698	1, 230, 977	967, 127	3, 784, 929	108, 233, 698	202.00

Heal th	Financial Systems	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Pre 6/23/2020 1:2	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVIC		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1 00	00100 CAP REL COSTS-BLDG & FIXT						1 1 00
1.00							1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	04 474 400					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	24, 474, 430	1 070 510				5.00
7.00	00700 OPERATION OF PLANT	287, 295	1, 270, 510				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	169, 610	0		0 750, 069		9.00
10.00	01000 DI ETARY	62, 043	0		0 0	274, 374	
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13.00	01300 NURSING ADMINISTRATION	0	0		0 0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 557	0		0 0	0	14.00
15.00	01500 PHARMACY	768	0		0 0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	88, 824	0		0 0	0	17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	
20100	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		20100
30.00	03000 ADULTS & PEDIATRICS	1, 158, 732	464, 229		0 274,066	274, 374	30.00
	ANCI LLARY SERVICE COST CENTERS	.,					
50.00	05000 OPERATI NG ROOM	3, 832, 969	750, 514		0 443,080	0	50.00
53.00	05300 ANESTHESI OLOGY	156, 139	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	27,653	0		0 0	0	
58.00	05800 MRI	260, 583	31, 526		0 18, 612	0	
60.00	06000 LABORATORY	107, 228	01,020		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	13, 354	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	317, 818	24, 241		0 14, 311	0	
69.00	06900 ELECTROCARDI OLOGY	65	24, 241		0 14, 311	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 352, 809	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 987, 424	0		0 0	0	
72.00	07300 DRUGS CHARGED TO PATIENTS	669, 102	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	009, 102	0		0 0	0	
76.97		-	0		0 0		
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0	
/6.99		0	0		0 0	0	76.99
~~~~~	OUTPATIENT SERVICE COST CENTERS		0	1			00.00
90.00	09000 CLINIC	0	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS		-	1	-1 -1		
	11500 AMBULATORY SURGICAL CENTER (D. P. )	3, 818, 154	0		0 0		115.00
118.00		19, 320, 127	1, 270, 510		0 750, 069	274, 374	118.00
	NONREI MBURSABLE COST CENTERS			1	-		
	07951 PHYS THERAPY PERFORMANCE CENTER	5, 154, 303	0		0 0	0	194.00
200.00							200.00
201.00		0	0		0 0		201.00
202.00	)   TOTAL (sum lines 118 through 201)	24, 474, 430	1, 270, 510		0 750, 069	274, 374	202.00

		RTHOPAEDI C HOSPT			Do		u of Form CMS-	2552-10
CUST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 15-0167		riod: om 01/01/2019 12/31/2019	Worksheet B Part I Date/Time Pre 6/23/2020 1:2	pared: 8 pm
	Cost Center Description	CAFETERIA M	AINTENANCE ( PERSONNEL	OF NURSI NG ADMI NI STRATI	I ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		11.00	12.00	13.00		14.00	15.00	
	GENERAL SERVICE COST CENTERS							
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSI NG SCHOOL	0 0 0 0 0 0 0			0 0 0 0 0 0	42, 265 0 0 0 0	3, 398 0 0 0 0	16.00 17.00 19.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0		0	0	0	0	
23.00	02300 PARAMED ED PRGM	0		0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0		0	0	0	0	30.00
50.00	ANCI LLARY SERVICE COST CENTERS	0		0	0	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	Ő	0	0	1
58.00	05800 MRI	0		0	0	0	0	1
60.00	06000 LABORATORY	0		0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0		0	0	0	0	1
66.00	06600 PHYSI CAL THERAPY	0		0	0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0		0	0	0	0	69.00
71.00 72.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0		0	0	42 245	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	0	42, 265 0	3, 398	
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	3, 378	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0		0	o	0	0	
76.99	07699 LI THOTRI PSY	0		0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	· · · ·		-				
90.00	09000 CLI NI C	0		0	0	0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS							92.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0	0	0		115.00
118.00	SUBTOTALS         (SUM OF LINES 1 through 117)           NONREIMBURSABLE         COST CENTERS	0		0	0	42, 265	3, 398	118.00
	07951 PHYS THERAPY PERFORMANCE CENTER	0		0	0	0	0	194.00
200.00								200.00
201.00		0		0	0	0	0	201.00 202.00
202.00	) TOTAL (sum lines 118 through 201)	0		0	0	42, 265	3 308	1202 00

COST A	Financial Systems 0 LLOCATION - GENERAL SERVICE COSTS		PT. AT PARKVIEW Provider CO	CN: 15-0167	Peri od:	u of Form CMS-2 Worksheet B	
CUSTA	LEUCATION - GENERAL SERVICE COSTS				From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
						I NTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	
		LIBRARY				APPRV	
		16.00	17.00	19.00	20.00	21.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
9.00 10.00	01000 DI ETARY						
							10.00
11.00	01100 CAFETERIA						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						14.00
							•
		0					15.00
	01600 MEDICAL RECORDS & LIBRARY	0	202.00/				16.00
	01700 SOCIAL SERVICE	0	392, 806		~		17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0		19.00
	02000 NURSI NG SCHOOL	0	0		0		20.00
	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0			0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0				23.00
30.00	03000 ADULTS & PEDIATRICS	0	392, 806		0 0	0	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	0	072,000		<u> </u>	ŭ	00.00
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50. 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
58.00	05800 MRI	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
76.99	07699 LI THOTRI PSY	0	0		0 0	0	76.99
~~ ~~	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLINIC	0	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
115 00	SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	0	115.00
115.00		0	-		0 0		•
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	392,806	I	0 0	0	118.00
10/ 00	07951 PHYS THERAPY PERFORMANCE CENTER	0	0		0 0		194. OC
200.00			0		0 0		200.00
200.00		_	_		0 0		200.00
201.00	-5	0	392, 806		0 0		201.00
		. 0			VI U		1202.0

Heal th	Financial Systems 0	RTHOPAEDI C HOSF	PT. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	Peri od:	Worksheet B	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	nared
					10 12/31/2017	6/23/2020 1:2	
		INTERNS &					
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS	PRGM		Residents Cost		
		APPRV			& Post		
					Stepdown Adjustments		
		22.00	23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	23.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			-			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE						17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000 NURSI NG SCHOOL						20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV						21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300 PARAMED ED PRGM		0	)			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	6, 529, 7	50 0	6, 529, 750	30.00
50.00	ANCI LLARY SERVICE COST CENTERS			10 111 11		40.444.400	50.00
	05000 OPERATING ROOM	0	0			18, 144, 183	
	05300 ANESTHESI OLOGY	0				690, 497	1
	05400 RADI OLOGY-DI AGNOSTI C	0	0			122, 290	
		0	0			1, 202, 518	
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		97 0 0 0	474, 197 0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
	06500 RESPIRATORY THERAPY	0			-	59,055	
	06600 PHYSI CAL THERAPY	0	0	1, 444, 04		1, 444, 042	1
	06900 ELECTROCARDI OLOGY	0	0			288	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	-		5, 982, 545	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C			30, 942, 939	
	07300 DRUGS CHARGED TO PATIENTS	0	0			2, 962, 376	
	07697 CARDI AC REHABI LI TATI ON	0	C		0 0	2, 702, 070	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0		
	07699 LI THOTRI PSY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS				0 0		/
90.00	09000 CLINIC	0	C	)	0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		-		0	-	92.00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	16, 885, 0	74 0	16, 885, 074	115.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0					
	NONREI MBURSABLE COST CENTERS	, -,					1
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	0	C	22, 793, 94	14 0	22, 793, 944	194.00
200.00		0	C		0 0	0	200.00
201.00		0	C		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	C	108, 233, 69	98 0	108, 233, 698	202.00

		RTHOPAEDI C HOSP	T. AT PARKVLEW		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/23/2020 1:2	pared:
			CAPI TAL REL	ATED COSTS		0/23/2020 1.2	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1					
2.00 4.00 5.00 7.00 8.00 9.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	0 2, 257, 472 0 0 0 0	0 282, 207 0 0 0	34, 79 317, 65 3		0 0 0 0 0 0	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0 0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	11.00 12.00 13.00 14.00
17.00 19.00 20.00 21.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	19.00 20.00 21.00
	02300 PARAMED ED PRGM	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1			1		
	03000 ADULTS & PEDIATRICS	0	346, 669	53, 66	4 400, 333	0	30.00
50. 00 53. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0000	560, 456 0	160, 14	5 720, 601 0 0	0 0 0	50.00 53.00 54.00
58. 00 60. 00	05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	23, 542 0	57, 14	1 80, 683 0 0	0	58.00 60.00 62.00
62. 30 65. 00	06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0 0 18, 103	32	0 0 0 0 6 18, 429	0 0 0	62.30 65.00 66.00
69. 00 71. 00 72. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	000000000000000000000000000000000000000	0	30, 16	0 0 0 0 0 0	0 0 0	69.00 71.00 72.00 73.00
76. 97 76. 98 76. 99	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY	0	0 0 0		0 0 0 0 0 0	0 0 0	76. 97 76. 98
90. 00 92. 00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0	0		0 0 0	0	92.00
118.00	NONREI MBURSABLE COST CENTERS	0 2, 257, 472	0 1, 230, 977	191, 22 845, 14			115.00 118.00
	07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments	0	0		6 121, 986 0 0 0	0	194. 00 200. 00 201. 00
202.00	TOTAL (sum lines 118 through 201)	2, 257, 472	1, 230, 977	967, 12	4, 455, 576	0	202.00

Heal th	Financial Systems 0	RTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVIC		6/23/2020 1:2 DI ETARY	8 pm
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 574, 471					5.00
7.00	00700 OPERATION OF PLANT	30, 221	347, 875				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	17, 842	0		0 17, 842		9.00
10.00	01000 DI ETARY	6, 526	0		0 0	6, 558	
11.00	01100 CAFETERI A	0	0		0 0	0	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	1,005	0		0 0	0	
15.00	01500 PHARMACY	81	0		0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	
17.00	01700 SOCIAL SERVICE	9, 343	0		0 0	0	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		1			-
30.00	03000 ADULTS & PEDIATRICS	121, 889	127, 109		0 6, 519	6, 558	30.00
	ANCI LLARY SERVICE COST CENTERS		0.05 1.03				
50.00	05000 OPERATI NG ROOM	403, 196	205, 497		0 10, 540	0	
53.00	05300 ANESTHESI OLOGY	16, 425	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,909	0		0 0	0	
58.00		27, 411	8, 632		0 443	0	58.00 60.00
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11, 280	0		0 0 0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPIRATORY THERAPY	1,405	0		0 0	0	
66,00	06600 PHYSI CAL THERAPY	33, 432	6, 637		0 340	0	66.00
69.00	06900 ELECTROCARDI OLOGY	55,452	0, 037		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 304	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	734, 983	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	70, 384	0		0 0	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	,0,001	0		0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
76.99	07699 LI THOTRI PSY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS			<u> </u>			92.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	401, 638	0		0 0	0	115.00
118.00		2, 032, 281	347, 875		0 17, 842	6, 558	118.00
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	542, 190	0		0 0	0	194.00
200.00	5		-			-	200.00
201.00			247 075		0 0 0 17.842		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 574, 471	347, 875	I	0 17, 842	0, 558	202.00

	Financial Systems 0	RTHOPAEDIC HOSP	Provider C	CN: 15-0167	Period:	u of Form CMS Worksheet B	2552-10
ALLUUF	THOW OF CATTIAL RELATED COSTS			ch. 13-0107	From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 6/23/2020 1:2	
	Cost Center Description	CAFETERI A M	AINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI (	CENTRAL ON SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	I		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	0					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 1,005		14.00
15.00	01500 PHARMACY	0	0		0 0	81	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	)	0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM	0	0	)	0 0	0	23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	30.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
58.00	05800 MRI	0	0		0 0	0	
60.00	06000 LABORATORY	0	0		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
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	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1,005	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	81	1
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	)	0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
76.99		0	0	)	0 0	0	76.99
90.00	OUTPATI ENT SERVICE COST CENTERS	0	0	1	0 0	0	90.00
	09000 CETNIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	,	0 0	0	90.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
	D 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	0	115.00
115 00		0	0		0 1,005		118.00
		<u>Ч</u>	0	1	- 1,000	01	
115.00 118.00							
118.00	NONREI MBURSABLE COST CENTERS	0	0	)	0 0	0	194.00
118.00	NONRE MBURSABLE COST CENTERS	0	0		0 0	0	194. 00 200. 00
118.00 194.00	NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments	0	0		0 0 0 0	0	

	Financial Systems 0 TION OF CAPITAL RELATED COSTS	RTHOLAEDIC 1103	PT. AT PARKVIEW Provider C	NI: 15 0167	Peri od:	eu of Form CMS-2 Worksheet B	2002-1
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider C	1	From 01/01/2019 To 12/31/2019	Part II	narodi
					10 12/31/2019	6/23/2020 1:28	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE		NURSING SCHOOL		
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY 16.00	17.00	19.00	20.00	APPRV 21.00	
	GENERAL SERVICE COST CENTERS	10100	11100	17100	20100	21100	
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 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00							10.00
11.00							11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						14.00
	01600 MEDICAL RECORDS & LIBRARY	C					16.00
	01700 SOCIAL SERVICE		9,343				17.00
	01900 NONPHYSICIAN ANESTHETISTS		7, 343		h		19.0
	02000 NURSI NG SCHOOL				0		20.0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	(			0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	(					22.00
	02300 PARAMED ED PRGM	C					23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		1
30.00	03000 ADULTS & PEDIATRICS	(	9, 343				30.00
	ANCI LLARY SERVI CE COST CENTERS		-				
	05000 OPERATING ROOM	0					50.00
	05300 ANESTHESI OLOGY	(					53.00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
	05800 MRI 06000 LABORATORY						58.00 60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL						62.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
	06500 RESPI RATORY THERAPY	(					65.00
66.00	06600 PHYSI CAL THERAPY	(					66.00
	06900 ELECTROCARDI OLOGY	C	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0 0				73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	C	0 0				76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76. 99	07699 LI THOTRI PSY	(	00				76. 99
	OUTPATIENT SERVICE COST CENTERS		-				
	09000 CLINIC	C	0				90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P. )	(					115.00
115.00					o o		118.00
110.00	NONREIMBURSABLE COST CENTERS	L C	<u>۱ ۶,343</u>		J <u></u>	0	
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	(					194.00
200.00					o o		200. 00
		(			0 0		201.00
201.00							

Heal th	Financial Systems C	RTHOPAEDIC HOSF	PT. AT PARKVLEW		In Lie	eu of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Peri od:	Worksheet B	
					From 01/01/2019 To 12/31/2019		nared
						6/23/2020 1:2	
		INTERNS &					
		RESIDENTS					
	Cost Center Description	SERVICES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS APPRV	PRGM		Residents Cost & Post		
		APPRV			Stepdown		
					Adjustments		
		22.00	23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
							11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSICIAN ANESTHETISTS						19.00
	02000 NURSI NG SCHOOL						20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
	02300 PARAMED ED PRGM	Ŭ	C				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1	-	·1		1	
30.00	03000 ADULTS & PEDI ATRI CS			671, 75	1 0	671, 751	30.00
	ANCILLARY SERVICE COST CENTERS						]
50.00	05000 OPERATING ROOM			1, 339, 83		1, 339, 834	50.00
	05300 ANESTHESI OLOGY			16, 42			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			2, 90	9 0	2, 909	54.00
	05800 MRI			117, 16			
	06000 LABORATORY			11, 28			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0		
	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0 0		
	06500 RESPI RATORY THERAPY			1, 40			
	06600 PHYSI CAL THERAPY			58, 83			
	06900 ELECTROCARDI OLOGY			142.20	7 0		69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT			142, 30			
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			735, 98			
	07697 CARDI AC REHABI LI TATI ON				0 0		
	07698 HYPERBARI C OXYGEN THERAPY				0 0		
	07699 LI THOTRI PSY				0 0	-	
/0. //	OUTPATIENT SERVICE COST CENTERS	II		1	0 0	0	/0. //
90.00	09000 CLINIC				0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
.2.00	SPECIAL PURPOSE COST CENTERS	<u> </u>				I	1.2.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P. )			592, 85	8 0	592, 858	115.00
118.00		0	C				
	NONREI MBURSABLE COST CENTERS		-			, ., ,	
194.00	07951 PHYS THERAPY PERFORMANCE CENTER			664, 17	6 0	664, 176	194.00
200.00	Cross Foot Adjustments	0	C		0 0		200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	C	4, 455, 57	6 0	4, 455, 576	202.00

		RTHOPAEDI C HOS				eu of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2019	Worksheet B-1	
					o 12/31/2019		
			LATED COSTS			6/23/2020 1:2	8 pm
		CAPITAL REI	LATED CUSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4. 00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	1.00	0/1	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	81, 464					1.00
	00200 CAP REL COSTS-MVBLE EQUIP		2, 798, 896				2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	37, 749, 905			4.00
	00500 ADMINISTRATIVE & GENERAL	18, 676		9, 997, 811	-24, 474, 430		1
	00700 OPERATION OF PLANT	0	919, 301	152, 152 0	0	983, 215	
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0	326, 382	0	0 580, 459	8.00 9.00
	01000 DI ETARY	0	93	192, 953	0	212, 331	
	01100 CAFETERIA	0	0	0	0	0	1
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	29, 727	0	32, 708	
	01500 PHARMACY	0	0	2, 390	0	2,630	
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	276, 106	0	303, 982	1
	02000 NURSI NG SCHOOL	0	0	0	0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	22, 942	155, 306	2, 873, 821	0	3, 965, 543	30.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	37,090	442 445	7 472 120	0	12 117 420	50.00
	05300 ANESTHESI OLOGY	37,090	463, 465 0	7, 472, 120 128, 343	0		
	05400 RADI OLOGY-DI AGNOSTI C	0	0	86, 013	0	94, 637	
	05800 MRI	1, 558	165, 368	506, 119	0	891, 797	
60.00	06000 LABORATORY	0	0	333, 528	0	366, 969	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 198	0	39, 765	0	45,701	
	06900 ELECTROCARDI OLOGY	1, 198	944	949, 107	0	1, 087, 672	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4, 629, 736	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23, 913, 250	1
	07300 DRUGS CHARGED TO PATIENTS	0	87, 305	709, 405	0	2, 289, 876	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	e e e e e e e e e e e e e e e e e e e	
		0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	90.00
	SPECIAL PURPOSE COST CENTERS		<u> </u>			<u> </u>	/2.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	553, 395	4, 706, 208			115.00
118.00		81, 464	2, 445, 865	28, 781, 950	-24, 474, 430	66, 119, 627	118.00
	NONREI MBURSABLE COST CENTERS	1			1		
	07951 PHYS THERAPY PERFORMANCE CENTER	0	353, 031	8, 967, 955	0	17, 639, 641	
200.00	· · · · · · · · · · · · · · · · · · ·						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 230, 977	067 127	3, 784, 929		24, 474, 430	201.00
202.00	Part I)	1,230,977	967, 127	3, 704, 929		24, 474, 430	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 110687	0. 345539	0. 100263		0. 292200	203.00
204.00				0		2, 574, 471	
	Part II)						
205.00				0. 000000		0. 030737	205.00
204 00	II) NAME adjustment amount to be allocated						206 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00							207.00
	Parts III and IV)						

ST A	LLOCATION - STATISTICAL BASIS		PT. AT PARKVIEW Provider C		In Lie Period: Ecom 01/01/2010	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
		7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		1				
	00100 CAP REL COSTS-BLDG & FIXT						1
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2
	00500 ADMINISTRATIVE & GENERAL						
	00700 OPERATION OF PLANT	62, 788	3				7
00	00800 LAUNDRY & LINEN SERVICE	C	0				8
	00900 HOUSEKEEPI NG	C	0	62, 78			9
	01000 DI ETARY	C	0		0 25, 607		10
					0 0	0	
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION					0	12
	01400 CENTRAL SERVICES & SUPPLY					0	
	01500 PHARMACY	C	o o		0 0	0	15
	01600 MEDI CAL RECORDS & LI BRARY	C	0		0 0	0	
00	01700 SOCIAL SERVICE	C	0		0 0	0	17
	01900 NONPHYSICIAN ANESTHETISTS	C	0 0		0 0	0	19
	02000 NURSI NG SCHOOL	C	0		0 0	0	20
	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	0		0 0	0	21
	02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM					0	
00	INPATIENT ROUTINE SERVICE COST CENTERS				0 0	0	2.
. 00	03000 ADULTS & PEDI ATRI CS	22, 942	2 0	22, 94	2 25, 607	0	30
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	37, 090		37, 09	0 0	0	50
	05300 ANESTHESI OLOGY	C	0		0 0	0	53
	05400 RADI OLOGY-DI AGNOSTI C	C	0		0 0	0	54
		1, 558		1, 55	8 0	0	58
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0	0	60
	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0 0	0	62
	06500 RESPI RATORY THERAPY	C	0		0 0	0	65
	06600 PHYSI CAL THERAPY	1, 198	0	1, 19	8 0	0	66
. 00	06900 ELECTROCARDI OLOGY	C	0		0 0	0	69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0 0		0 0	0	7'
	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0		0 0	0	72
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION				0 0	0	1
	07698 HYPERBARI C OXYGEN THERAPY					0	
	07699 LI THOTRI PSY				0 0	0	
	OUTPATIENT SERVICE COST CENTERS			1	-, -,	-	
	09000 CLI NI C	C	0 0		0 0	0	90
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS					0	1110
5.00 B.00	11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117)	62, 788			8 25,607		115
5.00	NONREI MBURSABLE COST CENTERS	02,760	, U	02,70	25,007	0	1.10
4.00	07951 PHYS THERAPY PERFORMANCE CENTER	C	0 0		0 0	0	194
0. OO		_					200
1.00							201
2.00		1, 270, 510	0	750, 06	9 274, 374	0	202
	Part I)	20 224010	0,000000	11 04405	7 10 714005	0.000000	200
3.00 4.00		20. 234918 347, 875					203
+. UU	Part II)	347,875	, 0	17, 84	2 6, 558	0	204
5.00		5. 540470	0. 000000	0. 28416	3 0. 256102	0.000000	205
6.00	NAHE adjustment amount to be allocated						206
7 00	(per Wkst. B-2)						00-
7.00	NAHE unit cost multiplier (Wkst. D,	1					207

	nancial Systems CATION - STATISTICAL BASIS	ORTHOPAEDIC HOS	PI.AI PARKVIEW Provider CC	N. 15_0167	In Lie Period:	u of Form CMS-2 Worksheet B-1	2552
JI ALLU	UNITON - STATISTICAL DASIS				From 01/01/2019		
					To 12/31/2019	Date/Time Prep 6/23/2020 1:28	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
		HOUSED)	(DIRECT NRSING	(COSTED	REQUIS.)	(TIME SPENT)	
		11003ED)	HRS)	REQUIS.)			
		12.00	13.00	14.00	15.00	16.00	
	IERAL SERVICE COST CENTERS	1	1				
-	00 CAP REL COSTS-BLDG & FIXT						1.
1	200 CAP REL COSTS-MVBLE EQUIP						2.
	00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL						4. 5.
	OO OPERATION OF PLANT						7.
	BOO LAUNDRY & LINEN SERVICE						8.
	POO HOUSEKEEPING						9
. 00 010	DOO DI ETARY						10.
. 00  011	OO CAFETERI A						11.
	200 MAINTENANCE OF PERSONNEL	0					12.
	800 NURSING ADMINISTRATION	0	0				13
	OO CENTRAL SERVICES & SUPPLY	0	0	10, 00			14
		0	0		0 10,000	0	15
	000 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16
	00 SOCIAL SERVICE		0		0 0	0	17   19
	200 NONPHYSICIAN ANESTHETISTS 200 NURSING SCHOOL		0		0 0	0	20
	00 I & R SERVICES-SALARY & FRINGES APPRV		0			0	20
	200 I &R SERVICES-OTHER PRGM COSTS APPRV		0			0	22
	BOO PARAMED ED PRGM	0	0		0 0	0	23
	ATLENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	0	0		0 0	0	30
	LLARY SERVICE COST CENTERS				1		
	DOO OPERATING ROOM	0			0 0	0	50
	BOO ANESTHESI OLOGY	0	0		0 0	0	53
	100 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54
	300 MRI 300 LABORATORY		0			0	58 60
	200 WHOLE BLOOD & PACKED RED BLOOD CELL		0			0	62
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62
	500 RESPI RATORY THERAPY		0 0		0 0	0	65
	00 PHYSI CAL THERAPY	0	0		0 0	0	66
00 069	POO ELECTROCARDI OLOGY	0	0		0 0	0	69
00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	10, 00		0	72
	BOO DRUGS CHARGED TO PATIENTS	0	0		0 10, 000	0	73
	97 CARDIAC REHABILITATION	0	0		0 0	0	76
	98 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76
	099 LI THOTRI PSY	0	0		0 0	0	76
	PATIENT SERVICE COST CENTERS	0	0		0 0	0	90
	200 OBSERVATION BEDS (NON-DISTINCT PART					0	90
	CIAL PURPOSE COST CENTERS						72
	600 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	0	115
3.00	SUBTOTALS (SUM OF LINES 1 through 117)			10, 00	-		118
	IREI MBURSABLE COST CENTERS						
	251 PHYS THERAPY PERFORMANCE CENTER	0	0		0 0		194
). 00	Cross Foot Adjustments						200
. 00	Negative Cost Centers				_		201
2.00	Cost to be allocated (per Wkst. B,	0	0	42, 26	5 3, 398	0	202
0	Part I)	0 00000	0,000000	1 22450	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0,000000	200
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	4. 22650		0.000000	
4.00	Cost to be allocated (per Wkst. B, Part II)			1, 00	5 81	0	204
5. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 10050	0 0. 008100	0.000000	205
		0.00000	0.00000	0. 10000	0.000100	0.000000	200
6.00	NAHE adjustment amount to be allocated						206
	(per Wkst. B-2)						
7.00	NAHE unit cost multiplier (Wkst. D,						207

0001 //	Financial Systems C LLOCATION - STATISTICAL BASIS	RTHOPAEDIC HOSE	PT. AT PARKVIEW	CN: 15-0167 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
					rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/23/2020 1:2	
					INTERNS &		
	Cost Center Description	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR		
		(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRI NGES APPRV	PRGM COSTS APPRV	
			TIME)	TIME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	
		17.00	19.00	20.00	21.00	22.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	10,000					16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000 NURSI NG SCHOOL	0		0			20.00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0			0	0	21.00 22.00
	02300 PARAMED ED PRGM	0				0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	10.000					
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	10,000	0	0	0	0	30.00
	05000 OPERATING ROOM	0	0			0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	53.00 54.00
	05800 MRI	0	0	0	0	0	58.00
	06000 LABORATORY	0	0	0	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.00 62.30
	06500 RESPI RATORY THERAPY	0				-	
			0	0	0	0	65.00
	06600 PHYSI CAL THERAPY	0	0	0	-	0	65. 00 66. 00
69.00	06900 ELECTROCARDI OLOGY	0 0 0	0		0	-	65.00 66.00 69.00
69.00 71.00 72.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0 0 0		0	0	0 0 0 0	65.00 66.00 69.00 71.00 72.00
69.00 71.00 72.00 73.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0			0 0 0	0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00
69.00 71.00 72.00 73.00 76.97	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0 0 0 0 0 0 0 0			0 0 0 0	0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97
69.00 71.00 72.00 73.00 76.97 76.98 76.99	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY	0 0 0 0 0 0 0 0			0 0 0 0 0	0 0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98
69.00 71.00 72.00 73.00 76.97 76.98 76.99	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY		0		0 0 0 0 0	0 0 0 0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 001PATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	,	0		0 0 0 0 0	0 0 0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	,	000000000000000000000000000000000000000				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.)	,	0				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	000000000000000000000000000000000000000				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00
69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 92. 00 115. 00 115. 00 118. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07000 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 017698 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER	0	000000000000000000000000000000000000000				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 007699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers	0 10,000 0					65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adj ustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0	000000000000000000000000000000000000000				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 118.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	0 10,000 0					65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 194.00 200.00 201.00 202.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00 202.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0 0 10,000 0 392,806				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 194.00 200.00 201.00 202.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 194.00 200.00 201.00 202.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 007699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 DBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NORREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0 0 10,000 0 392,806 39.280600				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 115.00 118.00 194.00 200.00 201.00 202.00 203.00 204.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 114.00 200.00 201.00 202.00 203.00 204.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	0 0 10,000 0 392,806 39.280600 9,343	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00 202.00 203.00 204.00 205.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 115.00 118.00 200.00 201.00 202.00 203.00 204.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part I) NAHE adjustment amount to be allocated (per Wkst. B-2)	0 0 10,000 0 392,806 39.280600 9,343	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				65.00 66.00 69.00 71.00 72.00 73.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 118.00 201.00 202.00 203.00 204.00 205.00 206.00
69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 114.00 200.00 201.00 202.00 203.00 204.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part I) NAHE adjustment amount to be allocated (per Wkst. B-2)	0 0 10,000 0 392,806 39.280600 9,343	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				65.00 66.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00 201.00 202.00 203.00 204.00 205.00

ST ALLOCA	ncial Systems 0 TION - STATISTICAL BASIS	RTHOPAEDI C HOSPT	Provider CCN: 15-0167	Period:	Worksheet B-1
				From 01/01/2019 To 12/31/2019	Date/Time Prepared
				1.5 1.2, 017 2017	6/23/2020 1:28 pm
	Cost Center Description	PARAMED ED PRGM			
		(ASSI GNED			
		TI ME) 23.00			
	AL SERVICE COST CENTERS				
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP				1.
	EMPLOYEE BENEFITS DEPARTMENT				4.
	ADMI NI STRATI VE & GENERAL				5.
00 00700	OPERATION OF PLANT				7.
-	LAUNDRY & LINEN SERVICE				8.
	HOUSEKEEPING				9.
1	DI ETARY CAFETERI A				10.
	MAINTENANCE OF PERSONNEL				11.
	NURSI NG ADMI NI STRATI ON				13.
. 00 01400	CENTRAL SERVICES & SUPPLY				14.
	PHARMACY				15.
	MEDICAL RECORDS & LIBRARY				16.
	SOCI AL SERVI CE NONPHYSI CI AN ANESTHETI STS				17.   19.
	NURSI NG SCHOOL				20.
	I &R SERVICES-SALARY & FRINGES APPRV				21.
	I&R SERVICES-OTHER PRGM COSTS APPRV				22.
	PARAMED ED PRGM	0			23.
	I ENT ROUTI NE SERVI CE COST CENTERS				
	ADULTS & PEDIATRICS	0			30.
	LARY SERVICE COST CENTERS	0			50.
	ANESTHESI OLOGY	0			53.
1	RADI OLOGY-DI AGNOSTI C	0			54.
. 00   05800		0			58.
	LABORATORY	0			60.
	WHOLE BLOOD & PACKED RED BLOOD CELL BLOOD CLOTTING FOR HEMOPHILIACS	0			62. 62.
	RESPIRATORY THERAPY	0			65.
	PHYSI CAL THERAPY	0			66.
. 00 06900	ELECTROCARDI OLOGY	o			69.
	MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.
	IMPL. DEV. CHARGED TO PATIENTS	0			72.
	DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0			73.
	HYPERBARI C OXYGEN THERAPY	0			76.
	LI THOTRI PSY	0			76.
	TIENT SERVICE COST CENTERS				
	CLINIC	0			90.
	OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS				92.
	AMBULATORY SURGICAL CENTER (D. P. )	0			115.
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	0			118.
	IMBURSABLE COST CENTERS				
	PHYS THERAPY PERFORMANCE CENTER	0			194.
0.00	Cross Foot Adjustments Negative Cost Centers				200.
1.00 2.00	Cost to be allocated (per Wkst. B,	0			201. 202.
2.00	Part I)				202.
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203.
4.00	Cost to be allocated (per Wkst. B,	0			204.
F 00	Part II)	0.000000			
5.00	Unit cost multiplier (Wkst. B, Part II)	0. 000000			205.
6.00	NAHE adjustment amount to be allocated	0			206.
	(per Wkst. B-2)				200.
7.00	NAHE unit cost multiplier (Wkst. D,	0. 000000			207.
	Parts III and IV)				

Health Financial Systems 0	RTHOPAEDI C HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/23/2020 1:2	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30. 00 03000 ADULTS & PEDIATRICS	6, 529, 750		6, 529, 7	50 0	6, 529, 750	30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	18, 144, 183		18, 144, 1	83 0	18, 144, 183	50.00
53. 00 05300 ANESTHESI OLOGY	690, 497		690, 4	97 0	690, 497	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 290		122, 2	90 0	122, 290	54.00
58. 00 05800 MRI	1, 202, 518		1, 202, 5	18 0	1, 202, 518	58.00
60. 00 06000 LABORATORY	474, 197		474, 1	97 0	474, 197	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	59, 055	0	59, 0	55 0	59, 055	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 444, 042	0	1, 444, 0	42 0	1, 444, 042	66.00
69. 00 06900 ELECTROCARDI OLOGY	288		2	88 0	288	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 982, 545		5, 982, 5	45 0	5, 982, 545	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 942, 939		30, 942, 9	39 0	30, 942, 939	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 962, 376		2, 962, 3	76 0	2, 962, 376	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0			0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0			0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 431, 300		1, 431, 3	00	1, 431, 300	92.00
SPECIAL PURPOSE COST CENTERS						1
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	16, 885, 074		16, 885, 0	74	16, 885, 074	115.00
200.00 Subtotal (see instructions)	86, 871, 054	0	86, 871, 0	54 0	86, 871, 054	200.00
201.00 Less Observation Beds	1, 431, 300		1, 431, 3	00	1, 431, 300	201.00
202.00 Total (see instructions)	85, 439, 754	0	85, 439, 7	54 0	85, 439, 754	202.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/23/2020 1:2	
			XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	7, 857, 025		7, 857, 02	5		30.00
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATING ROOM	97, 180, 315	101, 346, 882			0.000000	
53. 00 05300 ANESTHESI OLOGY	9, 526, 790	8, 596, 462			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 838, 796	3, 119, 263			0. 000000	
58. 00 05800 MRI	11, 144	5, 937, 567		1 0. 202148	0.00000	
60. 00 06000 LABORATORY	1, 831, 329	529, 684	2, 361, 01		0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0. 000000	0.00000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0. 000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	142, 023	28, 618			0.00000	
66. 00 06600 PHYSI CAL THERAPY	3, 815, 218	898, 740			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	36, 047	22, 308	58, 35	5 0. 004935	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 426, 551	15, 616, 346	27, 042, 89	7 0. 221224	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	94, 139, 887	30, 962, 678			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 799, 491	8, 514, 519	21, 314, 01	0 0. 138987	0.00000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0. 000000	0.000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0.000000	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0.000000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0.000000	0. 000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 335, 377	1, 335, 37	7 1. 071832	0.00000	92.00
SPECIAL PURPOSE COST CENTERS						1
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	88, 820, 575	88, 820, 57	5		115.00
200.00 Subtotal (see instructions)	240, 604, 616	265, 729, 019	506, 333, 63	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	240, 604, 616	265, 729, 019	506, 333, 63	5		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/23/2020 1:2	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 091394				50.00
53. 00 05300 ANESTHESI OLOGY	0. 038100				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 024665				54.00
58.00 05800 MRI	0. 202148				58.00
60. 00 06000 LABORATORY	0. 200845				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 346077				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 306333				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 004935				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 221224				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247341				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 138987				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000				76. 98
76. 99 07699 LI THOTRI PSY	0.000000				76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.071832				92.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	ORTHOPAEDI C HOSF	T. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/23/2020 1:2	
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 500 750		( 500 7		( 500 750	
30. 00 03000 ADULTS & PEDI ATRI CS	6, 529, 750		6, 529, 7	50 0	6, 529, 750	30.00
ANCI LLARY SERVICE COST CENTERS	10 111 100		10 111 1		40.444.400	50.00
50. 00 05000 OPERATING ROOM	18, 144, 183		18, 144, 1		18, 144, 183	
53. 00 05300 ANESTHESI OLOGY	690, 497		690, 4		690, 497	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 290		122, 2		122, 290	
58.00 05800 MRI 60.00 06000 LABORATORY	1, 202, 518		1, 202, 5		1, 202, 518	
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	474, 197		474, 1	97 0	474, 197 0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPIRATORY THERAPY	59,055	0	59, 0		59,055	•
66. 00 06600 PHYSI CAL THERAPY	1, 444, 042	0			1, 444, 042	•
69. 00 06900 ELECTROCARDI OLOGY	288	0		88 0	288	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 982, 545		5, 982, 5		5, 982, 545	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 942, 939		30, 942, 9		30, 942, 939	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 962, 376		2, 962, 3		2, 962, 376	
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 702, 370		2,702,5	0 0	2, 702, 370	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76. 99 07699 LI THOTRI PSY	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
90. 00 09000 CLINIC	0			0 0	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 431, 300		1, 431, 3		1, 431, 300	
SPECIAL PURPOSE COST CENTERS	.,,		.,		.,	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	16, 885, 074		16, 885, 0	74	16, 885, 074	115.00
200.00 Subtotal (see instructions)	86, 871, 054	0			86, 871, 054	
201.00 Less Observation Beds	1, 431, 300		1, 431, 3	00	1, 431, 300	201.00
202.00 Total (see instructions)	85, 439, 754	0	85, 439, 7	54 0	85, 439, 754	202 00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/23/2020 1:2	
	_		e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 057 005			-		
30. 00 03000 ADULTS & PEDI ATRI CS	7, 857, 025		7, 857, 02	5		30.00
ANCI LLARY SERVI CE COST CENTERS		4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.	100 507 40	-	0.00000	
50. 00 05000 OPERATI NG ROOM	97, 180, 315	101, 346, 882			0.00000	
53. 00 05300 ANESTHESI OLOGY	9, 526, 790	8, 596, 462			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 838, 796	3, 119, 263			0.00000	
58. 00 05800 MRI	11, 144	5, 937, 567			0.00000	
60. 00 06000 LABORATORY	1, 831, 329	529, 684	2, 361, 01		0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0. 000000	0.00000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	142, 023	28, 618			0.00000	
66. 00 06600 PHYSI CAL THERAPY	3, 815, 218	898, 740			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	36, 047	22, 308			0.00000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	11, 426, 551	15, 616, 346			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	94, 139, 887	30, 962, 678			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 799, 491	8, 514, 519	21, 314, 01		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0. 000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0 0.00000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0 0. 000000	0.00000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 335, 377	1, 335, 37	7 1. 071832	0.00000	92.00
SPECIAL PURPOSE COST CENTERS				-		1.15 .00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	88, 820, 575				115.00
200.00 Subtotal (see instructions)	240, 604, 616	265, 729, 019	506, 333, 63	5		200.00
201.00 Less Observation Beds		0/F 700		_		201.00
202.00  Total (see instructions)	240, 604, 616	265, 729, 019	506, 333, 63	5		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-2!	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prep 6/23/2020 1:28	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 091394				50.00
53. 00 05300 ANESTHESI OLOGY	0. 038100				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 024665				54.00
58.00 05800 MRI	0. 202148				58.00
60. 00 06000 LABORATORY	0. 200845				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 346077				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 306333				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 004935				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 221224				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247341				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 138987				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 071832				92.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				1	15.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	18, 144, 183	1, 339, 834	16, 804, 34	9 0	0	50.00
53.00 05300 ANESTHESI OLOGY	690, 497	16, 425	674, 07	2 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	122, 290	2, 909	119, 38	0	0	54.00
58. 00 05800 MRI	1, 202, 518	117, 169	1, 085, 34	9 0	0	58.00
60. 00 06000 LABORATORY	474, 197	11, 280	462, 91	7 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	59,055	1, 405	57,65	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 444, 042	58, 838	1, 385, 20	04 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	288	7	28		0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	5, 982, 545	142, 304	5, 840, 24	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 942, 939	735, 988	30, 206, 95	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 962, 376	100, 632	2, 861, 74	4 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 431, 300	147, 245	1, 284, 05			92.00
SPECIAL PURPOSE COST CENTERS						1
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	16, 885, 074	592, 858	16, 292, 21	6 0	0	115.00
200.00 Subtotal (sum of lines 50 thru 199)	80, 341, 304	3, 266, 894				200.00
201.00 Less Observation Beds	1, 431, 300	147, 245				201.00
202.00 Total (line 200 minus line 201)	78, 910, 004					202.00

Health Financial Systems	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part II Date/Time Pre 6/23/2020 1:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,				
	Operating Cost			6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	18, 144, 183	198, 527, 197	0. 09139	94		50.00
53. 00 05300 ANESTHESI OLOGY	690, 497					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 290	4, 958, 059	0. 02466	55		54.00
58. 00 05800 MRI	1, 202, 518	5, 948, 711	0. 20214	18		58.00
60. 00 06000 LABORATORY	474, 197	2, 361, 013	0. 20084	15		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	00		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00		62.30
65. 00 06500 RESPI RATORY THERAPY	59, 055		0. 3460	77		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 444, 042	4, 713, 958	0. 30633	33		66.00
69. 00 06900 ELECTROCARDI OLOGY	288	58, 355	0.00493	35		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 982, 545	27, 042, 897	0. 22122	24		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 942, 939	125, 102, 565	0. 24734	41		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 962, 376	21, 314, 010	0. 13898	37		73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.0000	00		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.0000	00		76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000	00		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 431, 300	1, 335, 377	1.07183	32		92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	16, 885, 074	88, 820, 575	0. 1901	)3		115.00
200.00 Subtotal (sum of lines 50 thru 199)	80, 341, 304	498, 476, 610				200.00
201.00 Less Observation Beds	1, 431, 300	0				201.00
202.00 Total (line 200 minus line 201)	78, 910, 004	498, 476, 610				202.00

Health Financial Systems (	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	NPATIENT ROUTINE SERVICE CAPITAL COSTS			Period: From 01/01/2019	Worksheet D Part I	
				To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
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	671, 751	C	671, 75	1 5, 730	117.23	30.00
200.00 Total (lines 30 through 199)	671, 751		671, 75	1 5, 730		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 370	160, 605				30.00
200.00 Total (lines 30 through 199)	1, 370	160, 605				200.00

Health Financial Systems	ORTHOPAEDI C HOSI			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	xvi i	Hospi tal	PPS	o pii
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	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	r	-	1	- I		
50.00 05000 OPERATING ROOM	1, 339, 834	198, 527, 197	0. 00674	9 28, 511, 169		
53. 00 05300 ANESTHESI OLOGY	16, 425	18, 123, 252	0. 00090	6 2, 959, 204	2, 681	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 909	4, 958, 059	0. 00058	7 569, 859	335	54.00
58. 00 05800 MRI	117, 169	5, 948, 711	0. 01969	7 4, 886		
60. 00 06000 LABORATORY	11, 280	2, 361, 013	0. 00477	8 608, 382	2, 907	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	1, 405	170, 641	0. 00823	4 19, 477	160	65.00
66. 00 06600 PHYSI CAL THERAPY	58, 838	4, 713, 958	0. 01248	2 1, 092, 681	13, 639	66.00
69. 00 06900 ELECTROCARDI OLOGY	7	58, 355	0.00012	0 34, 304	4	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 304	27, 042, 897	0. 00526	2 3, 543, 772	18, 647	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	735, 988	125, 102, 565	0. 00588	3 27, 902, 729	164, 152	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	100, 632	21, 314, 010	0.00472	1 3, 664, 752	17, 301	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	147, 245	1, 335, 377	0. 11026	5 0	0	92.00
200.00 Total (lines 50 through 199)	2, 674, 036	409, 656, 035		68, 911, 215	412, 344	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 15-0167       Period: Form of 1/01/2019       Worksheet D         Form of 1/01/2019       Form of 1/01/2019       Provider CCN: 15-0167       Period: Form of 1/01/2019       Part II I         Cost Center Description       Nursing School Nursing School Nursing School Allied Health Allied Health Cost       All Other Medical Education Cost         Marking       All other Medical       All other Medical       All other Medical         More Cost Center Description       Nursing School Nursing School Nursing School Allied Health Cost       All other Medical         More Cost Center Description       Nursing School Nursing School Nursing School Nursing School Allied Health Cost       All Other Medical Education Cost         30.00       03000 ADULTS & PEDIATRICS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <th></th> <th>ORTHOPAEDIC HOS</th> <th></th> <th></th> <th>In Lie</th> <th>eu of Form CMS-</th> <th>2552-10</th>		ORTHOPAEDIC HOS			In Lie	eu of Form CMS-	2552-10
To         12/31/2019         Date/Time         Prepared: 6/23/2020 1: 28 pm           Cost Center Description         Nursing School Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Cost         Allied Health Medical Education Cost           30.00         03000         ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C				
Image: Notice of the synthesis of						Date/Time Pre	
Cost Center Description       Nursing School Post-Stepdown Adjustments       Allied Health Post-Stepdown Adjustments       Allied Health Cost       Allied Health Medical Education Cost         30.00       INPATIENT ROUTINE SERVICE COST CENTERS 30.00       1A       1.00       2A       2.00       3.00         200.00       Total (Lines 30 through 199)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<							28 pm
Post-Stepdown Adjustments     Post-Stepdown Adjustments     Cost     Medical Education Cost       30.00     INPATI ENT ROUTI NE SERVICE COST CENTERS     1A     1.00     2A     2.00     3.00       30.00     ADULTS & PEDI ATRICS     0     0     0     0     0     0       200.00     Total (Lines 30 through 199)     0     0     0     0     0     0       Cost Center Description     Swing-Bed Adjustment Amount (see instructions)     Total Costs minus col. 4)     Total Patient Days     Per Diem (col. 5 ÷ col. 6)     Inpatient Program Days       30.00     ADULTS & PEDI ATRICS     0     0     0     0     0       Cost Center Description     Swing-Bed Adjustment Adjustment Amount (see instructions)     Total Costs in tuc col. 4)     Total Patient Program Days     Per Diem (col. 1 npatient Program Days     Inpatient Program Days       30.00     ADULTS & PEDI ATRICS     0     0     5.00     6.00     7.00     8.00       200.00     Total (Lines 30 through 199)     0     0     5,730     0.00     1,370     30.00       200.00     Total (Lines 30 through 199)     0     0     5,730     0.00     1,370     30.00       200.00     Total (Lines 30 through 199)     0     0     5,730     0.00     1,370     20.00 <td></td> <td>L</td> <td></td> <td></td> <td></td> <td></td> <td></td>		L					
Adj ustments         Adj ustments         Education Cost           1A         1.00         2A         2.00         3.00           30.00         03000         ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	Cost Center Description						
INPATI ENT ROUTI NE SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
INPATI ENT ROUTI NE SERVICE COST CENTERS         30. 00       03000 ADULTS & PEDI ATRI CS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0							
30.00         03000         ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<		1A	1.00	2A	2.00	3.00	
200.00       Total (lines 30 through 199)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0							
Cost Center Description       Swing-Bed Adjustment Amount (see instructions)       Total Costs (sum of cols. 1 through 3, minus col. 4)       Total Patient Days       Per Diem (col. 5 ÷ col. 6)       Inpatient Program Days         30.00       03000       ADULTS & PEDIATRICS 200.00       0       0       0       0.00       7.00       8.00         200.00       Total (lines 30 through 199)       0       0       5,730       0.00       1,370       30.00         Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       0       0       5,730       1,370       200.00		0	0		0 0	-	
Adjustment Amount (see instructions)       (sum of cols. 1 through 3, minus col. 4)       Days       5 ÷ col. 6)       Program Days         1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       3       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	00		0 0		200.00
Amount (see instructions)         1 through 3, minus col. 4)	Cost Center Description						
instructions)         minus col. 4)               4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDIATRICS         0         0         5,730         0.00         1,370         30.00           200.00         Total (lines 30 through 199)         0         5,730         0.00         1,370         200.00           Cost Center Description           Inpatient Program Pass-Through Cost (col. 7 x col. 8)         0         5,730         0.00         1,370         200.00				Days	5 ÷ col. 6)	Program Days	
4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDIATRICS         0         0         5,730         0.00         1,370         30.00           200.00         Total (Lines 30 through 199)         0         5,730         1,370         200.00           Cost Center Description           Inpatient Program Pass-Through Cost (col. 7 x col. 8)           9.00         9.00							
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         0         0         5,730         0.00         1,370         30.00           200.00         Total (lines 30 through 199)         0         5,730         1,370         200.00           Cost Center Description           Inpatient Program Pass-Through Cost (col. 7 x col. 8)         9.00							
30.00         03000         ADULTS & PEDIATRICS         0         0         5,730         0.00         1,370         30.00           200.00         Total (lines 30 through 199)         Inpatient         0         5,730         1,370         200.00           Cost Center Description           Inpatient           Pass-Through         Cost (col. 7 x         col. 8)         9.00         9.00         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         200.00         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370         1,370		4.00	5.00	6.00	7.00	8.00	
200.00     Total (lines 30 through 199)     0     5,730     1,370 200.00       Cost Center Description       Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			1	1	-1		-
Cost Center Description Program Pass-Through Cost (col. 7 x col. 8) 9.00		0	0				
Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00			0	5, 73	0	1, 370	200.00
Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00	Cost Center Description						
Cost (col. 7 x							
<u>col. 8)</u> 9.00							
9.00							
			-				
INPATIENT ROUTINE SERVICE COST CENTERS		9.00					
		-	-				
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00		-					
200.00         Total (lines 30 through 199)         0         200.00	200.00   Total (lines 30 through 199)	0					200. 00

Health Financial Systems C	RTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/23/2020 1:2	pared: 8 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description				I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0	C	)	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 0	0	54.00
58.00 05800 MRI	0	C	)	0 0	0	58.00
60. 00 06000 LABORATORY	0	C	)	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	c c		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	c c		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c c		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	c c		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	c c		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	l c		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLINIC	0	C	)	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	c		0 0	0	200.00

Health Financial Systems (	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2019		
				To 12/31/2019	Date/Time Prep 6/23/2020 1:23	
		Title	XVIII	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		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	1.00	F 00	( 00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				100 507 407	0.00000	50.00
50. 00 05000 OPERATING ROOM	0	0		0 198, 527, 197		
53. 00 05300 ANESTHESI OLOGY	0	0		0 18, 123, 252		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 4, 958, 059		
58. 00 05800 MRI	0	0		0 5, 948, 711		
	0	0		0 2, 361, 013		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0. 000000	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0.00000	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 170, 641	0.00000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 713, 958		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 58, 355		69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 27, 042, 897		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 125, 102, 565		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 21, 314, 010		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0	0		0 0		
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0		0 1, 335, 377		
200.00  Total (lines 50 through 199)	0	0		0 409, 656, 035		200. 00

Health Financial Systems C	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	EVICE OTHER PASS	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/23/2020 1:2	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.000000	28, 511, 169		0 19, 567, 185	0	50.00
53. 00 05300 ANESTHESI OLOGY	0.000000	2, 959, 204		0 1, 520, 070	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	569, 859		0 664, 802	0	54.00
58. 00 05800 MRI	0.000000	4, 886		0 1, 130, 665	0	58.00
60. 00 06000 LABORATORY	0. 000000	608, 382		0 149, 608	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	19, 477		0 3, 244	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 092, 681		0 384, 544	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	34, 304		0 3, 738	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 543, 772		0 3, 229, 755	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	27, 902, 729		0 8, 336, 539	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 664, 752		0 1, 889, 153	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0.000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 393, 740	0	92.00
200.00   Total (lines 50 through 199)		68, 911, 215		0 37, 273, 043		200. 00

Health Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM	0. 091394			0 0	1, 788, 323	
53.00 05300 ANESTHESI OLOGY	0. 038100			0 0	57, 915	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 024665			0 0	16, 397	
58. 00 05800 MRI	0. 202148			0 0	228, 562	•
60. 00 06000 LABORATORY	0. 200845			0 0	30, 048	•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 346077			0 0	1, 123	
66. 00 06600 PHYSI CAL THERAPY	0. 306333			0 0	117, 799	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 004935	3, 738		0 0	18	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 221224	3, 229, 755		0 0	714, 499	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247341	8, 336, 539		0 0	2, 061, 968	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 138987	1, 889, 153		0 0	262, 568	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 071832	393, 740		0 0	422, 023	92.00
200.00 Subtotal (see instructions)		37, 273, 043		0 0	5, 701, 243	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		37, 273, 043		0 0	5, 701, 243	202.00

Health Financial Systems 0	ORTHOPAEDI C HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/23/2020 1:2	
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
58. 00 05800 MRI	0	0				58.00
60. 00 06000 LABORATORY	0	0				60,00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62,00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY THERAPY	0	0				65,00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0	1			202.00

Health Financial Systems (	ORTHOPAEDIC HOSI	PT. AT PARKVI EW		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 8 pm
	_	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	3,00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00			4.00	1	
30. 00 ADULTS & PEDIATRICS	671, 751		671, 75			
200.00 Total (lines 30 through 199)	671, 751		671, 75	1 5, 730		200.00
Cost Center Description	Inpatient Program days	Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	269	31, 535				30.00
200.00 Total (lines 30 through 199)	269	31, 535	1			200. 00

	RTHOPAEDIC HOSI			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Titl	e XIX	Hospi tal	PPS	o piii
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(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	
ANCI LLARY SERVI CE COST CENTERS	1	-	1	1		
50. 00 05000 OPERATI NG ROOM	1, 339, 834					
53. 00 05300 ANESTHESI OLOGY	16, 425					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 909				3	54.00
58. 00 05800 MRI	117, 169			-	0	00.00
60. 00 06000 LABORATORY	11, 280	2, 361, 013			20	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000		0	02.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	02.00
65. 00 06500 RESPI RATORY THERAPY	1, 405		0. 00823		1	65.00
66. 00 06600 PHYSI CAL THERAPY	58, 838					
69. 00 06900 ELECTROCARDI OLOGY	7	58, 355				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 304					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	735, 988					
73.00 07300 DRUGS CHARGED TO PATIENTS	100, 632	21, 314, 010			189	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	1 / 01 / 0
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	0	0.00000		0	1 201 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	147, 245		0. 11026	5 0	0	1 . 2. 00
200.00   Total (lines 50 through 199)	2, 674, 036	409, 656, 035		594, 503	3, 490	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 15-0167       Period: From 01/01/2019 To 12/31/2019       Worksheet D Part 111 Date/Time Prepared: 6/23/2020 12.8 pm         Cost Center Description       Nursing School Nursing School Auursing School Adjustments       Allied Health		ORTHOPAEDIC HOS			In Lie	u of Form CMS-	2552-10
Cost Center Description         Nursing School Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Cost         Allied Health Allied Health Cost         Allied Health Education Cost           INPATIENT ROUTINE SERVICE COST CENTERS         1A         1.00         2A         2.00         3.00           0000000         030000         ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P</td> <td>ASS THROUGH COS</td> <td>TS Provider C</td> <td></td> <td></td> <td></td> <td></td>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C				
Cost Center Description       Nursing School Post-Stepdown Adjustments       Allied Health Post-Stepdown Adjustments       Allied Health Cost Adjustments       Allied Health Cost Education Cost         INPATIENT ROUTINE SERVICE COST CENTERS       1A       1.00       2A       2.00       3.00         INPATIENT ROUTINE SERVICE COST CENTERS       0       0       0       0       0       0         Cost Center Description       Swing-Bed Adjustment Adjustment Adjustment       Total Costs Sum of cols. 1 through 3, instructions)       Total Costs. Days       Total Patient 5 ÷ col. 6)       Per Diem (col. Program Days       Inpatient Program Days         30.00       03000       ADULTS & PEDIATRICS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0					To 12/31/2019		
Post-Stepdown Adj ustments         Post-Stepdown Adj ustments         Cost Adj ustments         Medical Education Cost Education Cost           30.00         0000 ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			Titl	e XIX	Hospi tal	PPS	
Adj ustments         Adj ustments         Education Cost           30.00         O3000 ADULTS & PEDI ATRI CS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
INPATI ENT ROUTI NE SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		Post-Stepdown	-	Post-Stepdow	n Cost	Medi cal	
INPATI ENT ROUTINE SERVICE COST CENTERS         30.00       03000 ADULTS & PEDI ATRICS       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		Adjustments		Adjustments		Education Cost	
30.00         O3000         ADULTS & PEDIATRICS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<		1A	1.00	2A	2.00	3.00	
200.00         Total (lines 30 through 199)         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	INPATIENT ROUTINE SERVICE COST CENTERS						
Cost Center Description       Swing-Bed Adjustment Amount (see instructions)       Total Costs (sum of cols. 1 through 3, minus col. 4)       Total Patient Days       Per Diem (col. 5 ÷ col. 6)       Inpatient Program Days         30.00       INPATIENT ROUTINE SERVICE COST CENTERS       0       0       6.00       7.00       8.00         30.00       200.00       Total (lines 30 through 199)       0       0       5,730       0.00       269         200.00       Total (lines 30 through 199)       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       0       0       5,730       0.00       269         30.00       INPATIENT ROUTINE SERVICE COST CENTERS       0       0       5,730       0.00       269         30.00       Total (lines 30 through 199)       Inpatient Program Pass-Through Cost (col. 7 x col. 8)       9.00       30.00         30.00       INPATIENT ROUTINE SERVICE COST CENTERS       0       30.00       30.00	30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
Adj ustment Amount (see instructions)       Days       5 ÷ col. 6)       Program Days         1 through 3, instructions)       1 through 3, instruc	200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Amount (see instructions)         1 through 3, minus col. 4)         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3         3 <t< td=""><td>Cost Center Description</td><td>Swi ng-Bed</td><td>Total Costs</td><td>Total Patien⁻</td><td>Per Diem (col.</td><td>I npati ent</td><td></td></t<>	Cost Center Description	Swi ng-Bed	Total Costs	Total Patien ⁻	Per Diem (col.	I npati ent	
instructions         minus col. 4)         instructions           4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDIATRICS         0         0         5,730         0.00         269         30.00           200.00         Total (lines 30 through 199)         0         0         5,730         0.00         269         200.00           Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8)         Poo         0         5,730         0.00         269         200.00           INPATIENT ROUTINE SERVICE COST CENTERS         9.00         30.00         30.00         30.00         30.00         30.00		Adjustment	(sum of cols.				
4.00         5.00         6.00         7.00         8.00           30.00         03000         ADULTS & PEDI ATRICS         0         0         5,730         0.00         269         30.00           200.00         Total (lines 30 through 199)         0         5,730         0.00         269         200.00           Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8)         9.00		Amount (see	1 through 3,	-			
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS         0         0         5, 730         0. 00         269         30. 00           200. 00         Total (Lines 30 through 199)         0         5, 730         0. 00         269         200. 00           Cost Center Description         Inpati ent Program Pass-Through Cost (col. 7 x col. 8)         P. 00         5, 730         269         200. 00           INPATI ENT ROUTI NE SERVI CE COST CENTERS         9. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         3		instructions)	minus col. 4)				
30. 00       03000       ADULTS & PEDIATRICS       0       0       5, 730       0. 00       269       30. 00         200. 00       Total (lines 30 through 199)       Inpatient       Program       269       200. 00       269       200. 00         Cost Center Description       Inpatient       Program       Pass-Through       Cost (col. 7 x       col. 8)       9. 00       0       0       30. 00       30. 00         INPATIENT ROUTINE SERVICE COST CENTERS         30. 00       03000       ADULTS & PEDIATRICS       0       30. 00		4.00	5.00	6.00	7.00	8.00	
200.00       Total (lines 30 through 199)       0       5,730       269 200.00         Cost Center Description         Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00         1NPATIENT ROUTINE SERVICE COST CENTERS         30.00       03000 ADULTS & PEDIATRICS       0       30.00							
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 330.00	30. 00 03000 ADULTS & PEDI ATRI CS	0	0	5, 73	0.00	269	30.00
Program Pass-Through Cost (col. 7 x col. 8) 9.00     Program Pass-Through Cost (col. 7 x col. 8) 9.00       INPATIENT ROUTINE SERVICE COST CENTERS       30.00     03000 ADULTS & PEDIATRICS       0     30.00	200.00 Total (lines 30 through 199)		0	5, 73	0	269	200.00
Pass-Through Cost (col. 7 x col. 8) 9.00       INPATI ENT ROUTI NE SERVI CE COST CENTERS       30.00     03000 ADULTS & PEDI ATRI CS       0     30.00	Cost Center Description	I npati ent					
Cost (col. 7 x col. 8) 9.00         Cost (col. 7 x 9.00           30.00         03000 ADULTS & PEDIATRICS         0         30.00		Program					
col. 8)         9.00           30.00         03000 ADULTS & PEDIATRICS         0         30.00		Pass-Through					
9.00           I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         03000 ADULTS & PEDI ATRI CS         0         30.00		Cost (col. 7 x					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS         0         30. 00		col. 8)					
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00		9.00					
	INPATIENT ROUTINE SERVICE COST CENTERS						
200.00   Total (lines 30 through 199) 0 200.00	30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
	200.00   Total (lines 30 through 199)	0					200.00

Health Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 8 pm
			e XIX	Hospi tal	PPS	
Cost Center Description				I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	00.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0	)	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	)	0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLINIC	0	0	)	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	( C		0 0	0	200.00

Health Financial Systems (	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period: From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	_	Titl	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		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-	1			
50. 00 05000 OPERATING ROOM	0	0		0 198, 527, 197		
53. 00 05300 ANESTHESI OLOGY	0	0		0 18, 123, 252		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 4, 958, 059		
58. 00 05800 MRI	0	0		0 5, 948, 711		
60. 00 06000 LABORATORY	0	0		0 2, 361, 013		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.00000	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0.00000	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 170, 641	0.00000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 713, 958		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 58, 355		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 27, 042, 897		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 125, 102, 565		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 21, 314, 010		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	T		T			
90. 00 09000 CLINIC	0	0		0 0		
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0		0 1, 335, 377		
200.00  Total (lines 50 through 199)	0	0	1	0 409, 656, 035		200. 00

Health Financial Systems C	ORTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre	
					6/23/2020 1:2	8 pm
		-	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)	40.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	000 007			0	50.00
50. 00 05000 OPERATING ROOM	0. 000000	280, 337		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	36, 014		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 200		0 0	0	54.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	4, 119		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	117		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 952		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	364		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	38, 520		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	184, 800		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	40, 080		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		594, 503		0 0	0	200. 00

Health Financial Systems 0	RTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Titl	e XIX	Hospi tal	PPS	
			Charges	-	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0. 091394				0	
53. 00 05300 ANESTHESI OLOGY	0. 038100		32, 70		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 024665		13, 91		0	54.00
58. 00 05800 MRI	0. 202148		29, 79		0	58.00
60. 00 06000 LABORATORY	0. 200845		3, 40	06 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 346077			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 306333	0	4, 06	04 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 004935	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 221224	0	71, 31	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 247341	0	104, 15	57 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 138987	0	33, 70	05 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		•	·			
90. 00 09000 CLI NI C	0. 000000	0	)	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 071832	0	5, 01	7 0	0	92.00
200.00 Subtotal (see instructions)		0	698, 64	7 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	698, 64	7 0	0	202.00

Health Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 6/23/2020 1:	
			e XIX	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	I			
50. 00 05000 OPERATING ROOM	36, 609	0				50.00
53. 00 05300 ANESTHESI OLOGY	1, 246					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	343					54.00
58. 00 05800 MRI	6,023	0				58.00
60. 00 06000 LABORATORY	684	. 0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0 0				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0 0				62.30
65. 00 06500 RESPI RATORY THERAPY	0	0	1			65.00
66. 00 06600 PHYSI CAL THERAPY	1, 245	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 777	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 762	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 685	0				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0 0				76.99
OUTPATIENT SERVICE COST CENTERS	-	-				
90. 00 09000 CLINIC	0	-				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 377		1			92.00
200.00 Subtotal (see instructions)	97, 751					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		_				
202.00 Net Charges (line 200 - line 201)	97, 751	0				202.00

	Financial Systems ORTHOPAEDIC HOSPT. AT F		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	ovider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prep 6/23/2020 1:28	
	Cost Contor Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, e	xcluding newborn)		5, 730	1.00
2.00	Inpatient days (including private room days, excluding swing-bed		ivata room dave	5, 730 0	
3.00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	TT you have only pr	Tvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed d	5 /		4, 474	4.00
5.00	Total swing-bed SNF type inpatient days (including private room d reporting period	ays) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room d	ays) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room da	vs) through December	31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ys) after December 3	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to th	e Program (excludinç	g swing-bed and	1, 370	9.00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruction	s)			
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enter		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX on		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 XIX on	ly (including privat	e room dave)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year,	enter 0 on this lir	ne)	0	13.00
14.00 15.00	Medically necessary private room days applicable to the Program ( Total nursery days (title V or XIX only)	excluding swing-bed	days)	0	14.00 15.00
16.00	Nursery days (title V or XIX only)			0	
17 00	SWING BED ADJUSTMENT	harvel December 21	· · · · · · · · · · · · · · · · · · ·	0.00	17 00
17.00	Medicare rate for swing-bed SNF services applicable to services t reporting period	nrougn December 31 c	or the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services a	fter December 31 of	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services th	rough December 31 of	f the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services af	tor Docombor 21 of t	ha cast	0.00	20. 00
20.00	reporting period	ter beceniber 51 01 t	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1 of the east report	ing ported (line	6, 529, 750	
22.00	Swing-bed cost applicable to SNF type services through December 3 $5 \times 10^{-10}$ x line 17)	T OF the cost report	ing period (rine	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reportir	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31	of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 o	f the cost reporting	n period (line 8	0	25.00
	x line 20)				
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (lin	e 21 minus line 26)		0 6, 529, 750	26.00 27.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0, 327, 730	27.00
28.00	General inpatient routine service charges (excluding swing-bed an	d observation bed ch	narges)	0	
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ li	ne 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 3	1)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	0 6, 529, 750	36.00 37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTM	ENTS			
38.00	Adjusted general inpatient routine service cost per diem (see ins			1, 139. 57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1, 561, 211	
40.00	Medically necessary private room cost applicable to the Program (			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + 1	ine 40)		1, 561, 211	41.00

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
			Title	e XVIII	Hospi tal	6/23/2020 1:2 PPS	28 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
. 00	Intensive Care Type Inpatient Hospital Units			1		I	43.
. 00	CORONARY CARE UNIT						43.
. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wk	st D_3 col 3	Line 200)			1.00 11,392,173	3 48.
00	Total Program inpatient costs (sum of lines			ons)		12, 953, 384	
00	PASS THROUGH COST ADJUSTMENTS	i i iii ougii io) (	000 111011 4011 4	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		12/ /00/00	
00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	160, 605	5 50.
~ ~							
00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	rom Wkst. D, s	sum of Parts II	412, 344	1 51
00	and IV) Total Program excludable cost (sum of lines	50 and 51)				572, 949	52
00	Total Program inpatient operating cost exclu	,	lated, non-phy	sician anestr	netist, and	12, 380, 435	
	medical education costs (line 49 minus line				·		
	TARGET AMOUNT AND LIMIT COMPUTATION					L	
	Program di scharges						
00 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (l	ine 56 minus	line 53)		57
00	Bonus payment (see instructions)	ing boot and to	ingot amount (i			0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	ompounded by the	0.00	59
	market basket						
00 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	) 60 ) 61
. 00	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see		3 (IIIIC3 04 X		the target		
00	Relief payment (see instructions)	,				c	62
00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			C	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Door	mbor 21 of the	oost reporti	ng partial (Cas	C	0 64
00	instructions) (title XVIII only)	its through bece		e cost reporti	ng period (see		04
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	cost reporting	period (See	C	65
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	C	) 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	o costs through	December 21	of the cost re	porting poriod		67
00	(line 12 x line 19)	le costs through	December 31 C		eportring perrou		
. 00	Title V or XIX swing-bed NF inpatient routir	e costs after D	ecember 31 of	the cost repo	orting period	C	68
	(line 13 x line 20)						
00	Total title V or XIX swing-bed NF inpatient					0	) 69
00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70
00	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line			,			72
00	Medically necessary private room cost applic	able to Program					73
00	Total Program general inpatient routine serv	•					74
00	Capital-related cost allocated to inpatient 26. line 45)	routine service	e costs (from V	vorksheet B, F	art II, column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces			•			79
00	Total Program routine service costs for comp		ost limitation	n (line 78 mir	nus Line 79)		80
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		)				81
00	Reasonable inpatient routine service cost film tation (						82
00	Program inpatient ancillary services (see in		,				84
00	Utilization review - physician compensation		ons)				85
00	Total Program inpatient operating costs (sum	of lines 83 th					86
0.0	PART IV - COMPUTATION OF OBSERVATION BED PAS						
11(1)	Total observation bed days (see instructions	<i>.</i> )				1, 256	
. 00	Adjusted general inpatient routine cost per	diam (lina 27 -	ling 2			1, 139. 57	7  88

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	671, 751	6, 529, 750	0. 10287	5 1, 431, 300	147, 245	90.00
91.00 Nursing School cost	0	6, 529, 750	0.00000	0 1, 431, 300	0	91.00
92.00 Allied health cost	0	6, 529, 750	0.00000	0 1, 431, 300	0	92.00
93.00 All other Medical Education	0	6, 529, 750	0. 00000			93.00

	Financial Systems ORTHOPAEDIC HOSPT ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0167	Period: From 01/01/2019	u of Form CMS-2 Worksheet D-1	
			To 12/31/2019	Date/Time Prep 6/23/2020 1:28	
		Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		5, 730	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	-bed and newborn days)	rivato room dave	5, 730 0	
	do not complete this line.	5, 5, 5,	rivate room days,		
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	4, 474 0	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) atter December	31 OF THE COST	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1	to the Program (excluding	g swing-bed and	269	9.00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato	room dave)	0	10.00
	through December 31 of the cost reporting period (see instruc	ctions)	5 .		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, et al. )		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)		5	0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	ns)		6, 529, 750	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportio	ng period (line 6	о	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	o	24.00
	$7 \times line$ 19) Swing-bed cost applicable to NF type services after December	•	0.	0	
25.00	x line 20)	ST OF the cost reporting	g period (inne o	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 6, 529, 750	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	1
30.00	Semi-private room charges (excluding swing-bed charges)			0	
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 mi	inus line 33)(see instru	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	6, 529, 750	
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			+
					1
38, 00		e instructions)		1, 139, 571	38 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see			1, 139. 57 306, 544	
38.00 39.00 40.00		e 38)		1, 139. 57 306, 544 0	39.00

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0167	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/23/2020 1:2	epare
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)						42.
00	Intensive Care Type Inpatient Hospital Units			1			1 42
. 00 . 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T						43.
. 00	BURN INTENSIVE CARE UNIT						44.
	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	ict D 2 col 2	Line 200)			1.00 89,309	9 48.
. 00	Total Program inpatient costs (sum of lines			ns)		395, 853	
. 00	PASS THROUGH COST ADJUSTMENTS			5137		373, 033	<u> </u>
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	31, 535	50.
	111)						
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	3, 490	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				35, 025	5 52
. 00	Total Program inpatient operating cost exclu	,	lated, non-phy	sician anestl	netist, and	360, 828	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
	Program di scharges					0	
00 00	Target amount per discharge Target amount (line 54 x line 55)					0. OC	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	C	
00	Bonus payment (see instructions)	5	<u>j</u>			C	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	updated and co	ompounded by the	0.00	59
~~	market basket					0.00	
. 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. OC	
. 00	which operating costs (line 53) are less that					C	
	amount (line 56), otherwise enter zero (see		, i i i i i i i i i i i i i i i i i i i		5		
	Relief payment (see instructions)					C	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			C	0 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	C	64
	instructions) (title XVIII only)	te through book		,	ng por rou (oco		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reportinț	g period (See	C	65
00	instructions)(title XVIII only)		(	· F ) ( + : + I - )() / I			
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I ONLY). FOR	C	66
00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	eporting period	C	67
	(line 12 x line 19)					-	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	C	68 (
	(line 13 x line 20)			(0)			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					L C	) 69
. 00	Skilled nursing facility/other nursing facil						70
00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line			25)			72
. 00	Medically necessary private room cost applic	0	•				73
00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74
	26, line 45)			.s. Konoot D, T			'
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu		rouldon roos	10)			78
00 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			· · · · · · · · · · · · · · · · · · ·	us line 70)		80
00	Inpatient routine service cost per diem limi				103 IIIC <i>11</i> )		81
00	Inpatient routine service cost limitation (I		)				82
00	Reasonable inpatient routine service costs (						83
. 00	Program inpatient ancillary services (see in		、 、				84
00	Utilization review - physician compensation						85
. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		n ougn 85)				86
. 00	Total observation bed days (see instructions					1, 256	5 87.
. 00	Adjusted general inpatient routine cost per		line 2)			1, 139. 57	
00							

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	671, 751	6, 529, 750	0. 10287	5 1, 431, 300	147, 245	90.00
91.00 Nursing School cost	0	6, 529, 750	0.00000	0 1, 431, 300	0	91.00
92.00 Allied health cost	0	6, 529, 750	0.00000	0 1, 431, 300	0	92.00
93.00 All other Medical Education	0	6, 529, 750	0.00000			93.00

Health Financial Systems 0	RTHOPAEDIC HOSPT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0167	Period: From 01/01/2019	Worksheet D-3	
			To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 339, 968		30.00
ANCI LLARY SERVI CE COST CENTERS					-
50.00 05000 OPERATI NG ROOM		0.09139			•
53. 00 05300 ANESTHESI OLOGY		0. 03810			•
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 02466			•
58. 00 05800 MRI		0. 20214		988	
60. 00 06000 LABORATORY		0. 20084		122, 190	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.3460		6, 741	
66. 00 06600 PHYSI CAL THERAPY		0. 30633		334, 724	•
69. 00 06900 ELECTROCARDI OLOGY		0. 00493			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 22122			•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 24734			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13898		509, 353	
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	10110
76. 99 07699 LI THOTRI PSY		0.0000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.07183		0	12.00
200.00 Total (sum of lines 50 through 94 and 9			68, 911, 215	11, 392, 173	
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			68, 911, 215		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Period: From 01/01/2019	Worksheet D-3	3
			To 12/31/2019	Date/Time Pre 6/23/2020 1:2	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			14, 623		30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 09139	280, 337	25, 621	50.00
53. 00 05300 ANESTHESI OLOGY		0. 03810	36, 014	1, 372	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 02466	5, 200	128	
58. 00 05800 MRI		0. 20214	8 0	0	58.00
60. 00 06000 LABORATORY		0. 20084		827	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 34607	7 117	40	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 30633		1, 517	
69. 00 06900 ELECTROCARDI OLOGY		0.00493	35 364	2	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 22122	38, 520	8, 522	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24734		45, 709	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13898	40, 080	5, 571	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76.98
76. 99 07699 LI THOTRI PSY		0.0000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1.07183	32 0	0	92.00
200.00 Total (sum of lines 50 through 94 and			594, 503	89, 309	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			594, 503		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 6/23/2020 1:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1 1.0
00	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (	see	8, 411, 995	
00	instructions)	e .	1 (		1
02	DRG amounts other than outlier payments for discharges occurri instructions)	ng on or after uctober	i (see	2, 566, 548	1.0
03	DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring	prior to October	0	1.0
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1.0
	October 1 (see instructions)	ar bondi gob bobar i ng		Ũ	
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0
02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2.0
03	Outlier payments for discharges occurring prior to October 1 (	(see instructions)		23, 002	2.0
04	Outlier payments for discharges occurring on or after October	1 (see instructions)		13, 790	
00 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	rtina period (see instru	ctions)	5, 808, 409 33. 56	
	Indirect Medical Education Adjustment				
00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.
00	FTE count for allopathic and osteopathic programs that meet th	ne criteria for an add-o	n to the cap for	0.00	6.
	new programs in accordance with 42 CFR 413.79(e)				_
00 01	MMA Section 422 reduction amount to the IME cap as specified u ACA § 5503 reduction amount to the IME cap as specified under			0.00	7.
01	cost report straddles July 1, 2011 then see instructions.	42 0110 3412.100(1)(1)(1		0.00	/.
00	Adjustment (increase or decrease) to the FTE count for allopat			0.00	8.
	affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).	/9(c)(2)(iv), 64 FR 2634	0 (May 12,		
01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8.
00	report straddles July 1, 2011, see instructions.			0.00	
02	The amount of increase if the hospital was awarded FTE cap slc under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng nospi tai	0.00	8.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (	see	0.00	9.
. 00	instructions) FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	rds	0.00	10.
. 00	FTE count for residents in dental and podiatric programs.	she year from your recor	43	0.00	
. 00	Current year allowable FTE (see instructions)			0.00	
. 00 . 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	ar ended on or after Ser	tember 30 1007	0.00	
. 00	otherwise enter zero.	a ended on or arter sep	telliber 30, 1997,	0.00	14.
. 00	Sum of lines 12 through 14 divided by 3.			0.00	
. 00 . 00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clos	sure		0.00	
. 00	Adjusted rolling average FTE count	Sure		0.00	
	Current year resident to bed ratio (line 18 divided by line 4)	).		0.000000	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
. 00	IME payment adjustment (see instructions)			0. 000000 0	
. 01	IME payment adjustment - Managed Care (see instructions)			0	
00	Indirect Medical Education Adjustment for the Add-on for § 422		ED 412 105	0.00	1 22
. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$ .	ent cap stots under 42 t	FK 412.105	0.00	23.
. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	
00	If the amount on line 24 is greater than -O-, then enter the l instructions)	ower of line 23 or line	24 (see	0.00	25.
00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
00	IME payments adjustment factor. (see instructions)			0.000000	27.
00	IME add-on adjustment amount (see instructions)			0	28.
01 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)	1		0	28. 29.
01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01	)		0	
00	Disproportionate Share Adjustment	ationt doub (co. 1. 1	ti anc)	0.00	1
00 00	Percentage of SSI recipient patient days to Medicare Part A pa Percentage of Medicaid patient days (see instructions)	itient days (see instruc	tions)	0.00 0.00	
. 00	Sum of Lines 30 and 31			0.00	
. 00		)			33.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 6/23/2020 1:23	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		0	0	
5. 01	Factor 3 (see instructions)		0. 00000000	0. 00000000	
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (s	ee 0	0	35.0
5. 03	instructions) Pro rata share of the hospital uncompensated care payment am	mount (coo instructions)	0	0	35.0
5. 03 5. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.		0	0	36.0
. 00	Additional payment for high percentage of ESRD beneficiary d				00.0
). 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.0
	652, 682, 683, 684 and 685 (see instructions)	0			
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41. (
	instructions)				
. 01	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGs 652, 682, 683, 68	4 0		41.0
2. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qual	lify for adjustment)	0.00		42. (
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43.0
	instructions)	(3e			
l. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44. (
	days)				
5.00	Average weekly cost for dialysis treatments (see instruction		0.00		45.
b. 00	Total additional payment (line 45 times line 44 times line 4	41.01)	0		46.
. 00	Subtotal (see instructions)		11, 015, 335		47.
. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48.
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction			11, 015, 335	49.
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			878, 282	
. 00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4, I	line 49 see instructions)		0	52.
8.00 .00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0	53. 54.
. 00	Islet isolation add-on payment			0	54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.
. 00	Cost of physicians' services in a teaching hospital (see int			0	56.
. 00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30	through 35).	0	57.
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 11 line 200)		0	58.
. 00	Total (sum of amounts on lines 49 through 58)			11, 893, 617	
. 00	Primary payer payments			0	
. 00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		11, 893, 617	
. 00	Deductibles billed to program beneficiaries			993, 270	
. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			0 18, 170	
. 00	Adjusted reimbursable bad debts (see instructions)			11, 811	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	66.
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10, 912, 158	
. 00	Credits received from manufacturers for replaced devices for	r applicable to MS-DRGs (	see instructions)	0	68.
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)	).(For SCH see instructio	ns)	0	69.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
. 50	Rural Community Hospital Demonstration Project (§410A Demons		instructions)	0	70.
. 87	Demonstration payment adjustment amount before sequestration	n		0	70.
	SCH or MDH volume decrease adjustment (contractor use only)	structions)		0	
. 88	Pioneer ACO demonstration payment adjustment amount (see ins	STERCTIONS)		0	70.
. 88 . 89				0	
. 88 . 89 . 90	HSP bonus payment HVBP adjustment amount (see instructions)				
. 88 . 89 . 90 . 91	HSP bonus payment HRR adjustment amount (see instructions)				
. 88 . 89 . 90 . 91 . 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.
). 88 ). 89 ). 90 ). 91 ). 92 ). 93 ). 94	HSP bonus payment HRR adjustment amount (see instructions)				70. 70.

	URSEMENT SETTLEMENT	Provider C		Period:	Worksheet E	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	
		Title	XVIII	Hospi tal	6/23/2020 1:2 PPS	8 pr
		in the		(уууу)	Amount	
				0	1.00	
	ustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70
	ding federal year for the period prior to 10/1)					
	ustment for federal fiscal year (yyyy) (Enter i			0	0	70
. 98 Low Volume Pay	ding federal year for the period ending on or at	rter IU/I)			0	70
	t amount (see instructions)					
, ,	ovider (line 67 minus lines 68 plus/minus lines	69 & 70)			10, 912, 158	
	adjustment (see instructions)	e, u , e,			218, 243	
	payment adjustment amount after sequestration				0	71
03 Sequestration	adjustment-PARHM pass-throughs					71
00 Interim paymer					10, 682, 339	
.01 Interim paymer					_	72
	tlement (for contractor use only)				0	
	tlement-PARHM (for contractor use only)	00 70 and			11 57/	
00 Balance due pr 73)	rovider/program (line 71 minus lines 71.01, 71.0	02, 72, and			11, 576	74
,	rovider/program-PARHM (see instructions)					74
	unts (nonallowable cost report items) in accorda	ance with			0	
	chapter 1, §115.2					
	D BY CONTRACTOR (lines 90 through 96)					
	ier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90
	e instructions)					
	er from Wkst. L, Pt. I, line 2 ier reconciliation adjustment amount (see insti	ructions)			0	
1 5	er reconciliation adjustment amount (see instru				0	
	to calculate the time value of money (see institut				0.00	
	money for operating expenses (see instructions)				0	
.00 Time value of	money for capital related expenses (see instruct	ctions)			0	96
				Prior to 10/1		
HSP Bonus Paym	pont Amount			1.00	2.00	-
	unt (see instructions)			0	0	1100
HVBP Adjustmer	unt (see instructions) It for HSP Bonus Payment			0	0	100
	unt (see instructions) nt for HSP Bonus Payment nt factor (see instructions)			0.000000000		
I. 00 HVBP adjustmer	t for HSP Bonus Payment	ns)		1	0. 0000000000	101
1.00 HVBP adjustmer 2.00 HVBP adjustmer HRR Adjustment	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment	ns)		0.0000000000000000000000000000000000000	0. 000000000000000000000000000000000000	101 102
1.00 HVBP adjustmer 2.00 HVBP adjustmer HRR Adjustment 3.00 HRR adjustment	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions)			0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103
<ol> <li>OO HVBP adjustmer</li> <li>OO HVBP adjustmer</li> <li>HRR Adjustment</li> <li>OO HRR adjustment</li> <li>OO HRR adjustment</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions)	s)	ctmont	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000	101 102 103
<ol> <li>1. 00 HVBP adjustmer</li> <li>2. 00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>HRR adjustment</li> <li>3. 00 HRR adjustment</li> <li>HRR adjustment</li> <li>Rural Communit</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment factor (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103 104
1.00 HVBP adjustmer 2.00 HVBP adjustmer HRR Adjustment 3.00 HRR adjustment 0.00 HRR adjustment Rural Communit 0.00 Is this the fi	nt for HSP Bonus Payment ht factor (see instructions) ht amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration page	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103 104
1.00 HVBP adjustmer 2.00 HVBP adjustmer HRR Adjustment 3.00 HRR adjustment 0.00 HRR adjustment Rural Communit 0.00 Is this the fi	nt for HSP Bonus Payment ht factor (see instructions) ht amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonstration pro- rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no.	s) tration) Adju		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103 104
<ol> <li>1. 00 HVBP adjustmer</li> <li>2. 00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>HRR adjustment</li> <li>HRR adjustment</li> <li>Rural Communit</li> <li>Rural Communit</li> <li>Contury Cures</li> <li>Cost Reimburse</li> <li>1. 00 Medicare inpati</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions by Hospital Demonstration Project (§410A Demonstration rst year of the current 5-year demonstration per Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin	s) tration) Adju eriod under t		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103 104 200
<ol> <li>1. 00 HVBP adjustmer</li> <li>2. 00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>HRR adjustment</li> <li>HRR adjustment</li> <li>Rural Communit</li> <li>Rural Communit</li> <li>Cost Reimburse</li> <li>Cost Reimburse</li> <li>Communicate and the set of the</li></ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin marges (see instructions)	s) tration) Adju eriod under t		0. 000000000 0 0. 0000	0. 000000000 0 0. 0000	101 102 103 104 200 201 202
<ol> <li>1. 00 HVBP adjustmer</li> <li>2. 00 HVBP adjustmer</li> <li>HRR Adjustmer</li> <li>HRR adjustment</li> <li>3. 00 HRR adjustment</li> <li>4. 00 HRR adjustment</li> <li>4. 00 Is this the ficentury Cures</li> <li>Cost Reimburse</li> <li>Coo Medicare inpat</li> <li>2. 00 Medicare disch</li> <li>3. 00 Case-mix adjust</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin narges (see instructions) stment factor (see instructions)	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202
1. 00 HVBP adjustmer 2. 00 HVBP adjustmer HRR Adjustment 3. 00 HRR adjustment 0. 00 HRR adjustment Rural Communit 0. 00 Is this the fi <u>Century Cures</u> <u>Cost Reimburse</u> 0. 00 Medicare disch 3. 00 Case-mix adjus <u>Computation of</u>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin marges (see instructions)	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202
<ol> <li>1. 00 HVBP adjustmer</li> <li>2. 00 HVBP adjustmert</li> <li>HRR Adjustment</li> <li>HRR adjustment</li> <li>Rural Communit</li> <li>00 HRR adjustment</li> <li>Rural Communit</li> <li>00 Is this the fi Century Cures</li> <li>Cost Reimburse</li> <li>00 Medicare inpat</li> <li>00 Medicare disch</li> <li>00 Case-mix adjus</li> <li>Computation of period)</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instructions) for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, line harges (see instructions) stment factor (see instructions) 5 Demonstration Target Amount Limitation (N/A in	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	102 103 104 200 201 202 203
<ul> <li>.00 HVBP adj ustmer</li> <li>.00 HVBP adj ustmer</li> <li>HRR Adj ustmert</li> <li>HRR adj ustment</li> <li>.00 HRR adj ustment</li> <li>Rural Communit</li> <li>.00 Is this the fi</li> <li>Century Cures</li> <li>Cost Reimburse</li> <li>.00 Medi care inpati</li> <li>.00 Medi care di sch</li> <li>.00 Case-mix adj us</li> <li>.00 Computation of period)</li> <li>.00 Medi care target</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instructions) for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonstr y Hospital Demonstration Project (§410A Demonstr ty Hospital Demonstration Project (§410A Demonstr trest year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, line harges (see instructions) stment factor (see instructions) 5 Demonstration Target Amount Limitation (N/A in tet amount	s) tration) Adju eriod under t ne 49)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203
<ul> <li>.00 HVBP adj ustmer</li> <li>HVBP adj ustmer</li> <li>HRR Adj ustmer</li> <li>HRR adj ustmer</li> <li>HRR adj ustmer</li> <li>Rural Communit</li> <li>00 HRR adj ustmer</li> <li>Rural Communit</li> <li>00 Is this the fi</li> <li>Century Cures</li> <li>Cost Reimburse</li> <li>.00 Medi care di sch</li> <li>.00 Medi care targe</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instructions) for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, line harges (see instructions) stment factor (see instructions) 5 Demonstration Target Amount Limitation (N/A in	s) tration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 204 204
00 HVBP adj ustmer HRR Adj ustmer HRR Adj ustmer HRR adj ustmer Rural Communit 00 HRR adj ustmer Rural Communit 00 Is this the fi Century Cures Cost Reimburse 00 Medi care di sch 00 Medi care di sch 00 Case-mi x adj us Computati on of period) 00 Case-mi x adj us 00 Medi care targe 00 Medi care targe 00 Medi care inpar	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin harges (see instructions) 5 Demonstration Target Amount Limitation (N/A in et amount sted target amount (line 203 times line 204)	s) tration) Adju eriod under t ne 49) n first year	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202
<ul> <li>.00 HVBP adjustmer</li> <li>.00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>a. 00 HRR adjustment</li> <li>8. 00 HRR adjustment</li> <li>Rural Communit</li> <li>00 Is this the fi Century Cures Cost Reimburse</li> <li>.00 Medicare disch</li> <li>00 Medicare targe</li> <li>.00 Medicare targe</li> <li>.00 Medicare targe</li> <li>.00 Medicare inpati</li> <li>.00 Medicare inpati</li> <li>.00 Medicare targe</li> <li>.00 Program reimbu</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin marges (see instructions) stment factor (see instructions) between the factor (see instructions) for Demonstration Target Amount Limitation (N/A in test amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 206
<ul> <li>.00 HVBP adjustmer</li> <li>.00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>8.00 HRR adjustment</li> <li>8.00 HRR adjustment</li> <li>00 HRR adjustment</li> <li>00 Is this the fi Century Cures</li> <li>Cost Reimburse</li> <li>.00 Medicare inpati</li> <li>00 Medicare targe</li> <li>.00 Medicare</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, line marges (see instructions) stment factor (see instructions) * Demonstration Target Amount Limitation (N/A in ested target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see inst A inpatient service costs (from Wkst. E, Pt. A,	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 206 207 208
<ul> <li>.00 HVBP adj ustmer</li> <li>.00 HVBP adj ustmer</li> <li>HRR Adj ustment</li> <li>HRR adj ustment</li> <li>.00 HRR adj ustment</li> <li>.00 HRR adj ustment</li> <li>.00 Is this the fi Century Cures Cost Reimburse</li> <li>.00 Medi care inpat</li> <li>.00 Medi care di sch</li> <li>.00 Medi care targe</li> <li>.00 Medi care targe</li> <li>.00 Medi care inpat</li> <li>.00 Medi care not inpat</li> <li>.00 Medi care inpat</li> <li>.00 Medi care Part</li> <li>.00 Medi care Part</li> <li>.00 Adj ustment to</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, line harges (see instructions) * Demonstration Target Amount Limitation (N/A in tet amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see ins: A inpatient service costs (from Wkst. E, Pt. A, Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
<ul> <li>.00 HVBP adjustmer</li> <li>.00 HVBP adjustmer</li> <li>.00 HVBP adjustmer</li> <li>.00 HRR adjustment</li> <li>.00 HRR adjustment</li> <li>.00 HRR adjustment</li> <li>.00 Is this the fi Century Cures</li> <li>.00 Medicare inpation</li> <li>.00 Medicare disch</li> <li>.00 Medicare targe</li> <li>.00 Medicare targe</li> <li>.00 Medicare inpation</li> <li>.00 Medicare inpation</li> <li>.00 Medicare inpation</li> <li>.00 Medicare targe</li> <li>.01 Medicare targe</li> <li>.02 Medicare targe</li> <li>.03 Medicare targe</li> <li>.04 Medicare</li> <li>.05 Medicare</li> <li>.06 Medicare</li> <li>.06 Medicare</li> <li>.07 Medicare</li> <li>.08 Medicare</li> <li>.08 Medicare</li> <li>.09 Medicare</li> <li>.00 Medicare<td>nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instructions) for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonstr rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, Iin marges (see instructions) 5 Demonstration Target Amount Limitation (N/A in tet amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see instructions) For an at the service costs (from Wkst. E, Pt. A, Medicare IPPS payments (see instructions) Future use</td><td>s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)</td><td>he 21st</td><td>0.0000000000000000000000000000000000000</td><td>0. 000000000 0 0. 0000 0 0 trati on</td><td>101 102 103 200 201 202 203 203 204 205 206 207 208 209 210</td></li></ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instructions) for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) ty Hospital Demonstration Project (§410A Demonstr rst year of the current 5-year demonstration pro- Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, Iin marges (see instructions) 5 Demonstration Target Amount Limitation (N/A in tet amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see instructions) For an at the service costs (from Wkst. E, Pt. A, Medicare IPPS payments (see instructions) Future use	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 0 trati on	101 102 103 200 201 202 203 203 204 205 206 207 208 209 210
<ul> <li>.00 HVBP adjustmer</li> <li>.00 HVBP adjustmer</li> <li>HRR Adjustment</li> <li>adjustment</li> </ul>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin harges (see instructions) stment factor (see instructions) between the factor (see instructions) f Demonstration Target Amount Limitation (N/A in tet amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see inst A inpatient service costs (from Wkst. E, Pt. A, Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
<ol> <li>1. 00 HVBP adjustmer HRR Adjustmer HRR Adjustmert HRR Adjustment</li> <li>2. 00 HRR adjustment</li> <li>3. 00 HRR adjustment</li> <li>4. 00 HRR adjustment</li> <li>6. 00 Is this the fi Century Cures Cost Reimburse</li> <li>6. 00 Medicare inpat</li> <li>6. 00 Medicare disch</li> <li>7. 00 Medicare target</li> <li>7. 00 Medicare target</li> <li>7. 00 Program reimbus</li> <li>7. 00 Program reimbus</li> <li>7. 00 Adjustment to</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions) t amount for HSP bonus payment (see instructions) y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration po Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin harges (see instructions) stment factor (see instructions) between the factor (see instructions) function the factor (see instructions) future use ent to Medicare IPPS payments (see instructions) FDPS versus Cost Reimbursement	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 trati on	101 102 103 104 201 202 203 204 205 206 207 208 209 210 211
<ol> <li>1. 00 HVBP adjustmer HRR Adjustmer HRR Adjustmer HRR Adjustment</li> <li>2. 00 HRR adjustment</li> <li>3. 00 HRR adjustment</li> <li>4. 00 HRR adjustment</li> <li>6. 00 Is this the fi Century Cures Cost Reimburse</li> <li>6. 00 Medicare inpat</li> <li>7. 00 Medicare targe</li> <li>6. 00 Adjustment to</li> <li>7. 00 Program reimbus</li> <li>7. 00 Adjustment to</li> <li>7. 00 Total adjustmet</li> </ol>	nt for HSP Bonus Payment nt factor (see instructions) nt amount for HSP bonus payment (see instruction for HSP Bonus Payment t factor (see instructions) t amount for HSP bonus payment (see instructions y Hospital Demonstration Project (§410A Demonst rst year of the current 5-year demonstration pa Act? Enter "Y" for yes or "N" for no. ment tient service costs (from Wkst. D-1, Pt. II, lin harges (see instructions) stment factor (see instructions) between the factor (see instructions) f Demonstration Target Amount Limitation (N/A in tet amount sted target amount (line 203 times line 204) tient routine cost cap (line 202 times line 205) Medicare Part A Inpatient Reimbursement ursement under the §410A Demonstration (see inst A inpatient service costs (from Wkst. E, Pt. A, Medicare IPPS payments (see instructions)	s) tration) Adju eriod under t ne 49) n first year ) tructions) , line 59)	he 21st	0.0000000000000000000000000000000000000	0. 000000000 0 0. 0000 0 trati on	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210

	Financial Systems ORTHOPAEDIC HOSPT. A ATION OF REIMBURSEMENT SETTLEMENT	AT PARKVIEW Provider CCN: 15-0167	In Lie Period: From 01/01/2019 To 12/31/2019		pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		5, 701, 243	•
3.00	OPPS payments			5, 210, 092	•
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			25, 935	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	•
6.00	Line 2 times line 5			0	•
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	•
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	1 11.00
	Reasonabl e charges				1
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	•
10.00	had such payment been made in accordance with 42 CFR §413.13(e		a onargobaere		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete onl)	y if line 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)		10 10) (300		20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			5, 236, 027	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	)		855, 190	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	-	ructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	2 and 23] (see	4, 380, 837	27.00
~~ ~~	instructions)	50)			
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			4, 380, 837	•
31.00	Primary payer payments			0	1
32.00	Subtotal (line 30 minus line 31)			4, 380, 837	32.00
~~ ~~	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICI	ES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11)				33.00 34.00
34.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			35, 122	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		21, 528	•
37.00	Subtotal (see instructions)			4, 403, 666	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	、 、		0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	)		0	39.50 39.97
39.97 39.98	Partial or full credits received from manufacturers for replac	ed devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	1
40.00	Subtotal (see instructions)			4, 403, 666	1
40.01	Sequestration adjustment (see instructions)			88, 073	•
40.02	Demonstration payment adjustment amount after sequestration			0	•
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			4, 293, 220	40.03
41.00	Interim payments-PARHM			4, 275, 220	41.00
42.00	Tentative settlement (for contractors use only)			0	1
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00	Balance due provider/program (see instructions)			22, 373	•
43.01	Balance due provider/program-PARHM (see instructions)	on with CMC Dut 15 0	chaptor 1	_	43.01
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with two Pub. 15-2,	спартег Г,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	•
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	•
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
, 00				. 0	, , , , , , , , , , , , , , , , , , , ,

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0167	Period: From 01/01/2019 To 12/31/2019		
		Title		Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		10, 682, 33	39 0	4, 293, 220 0	1. ( 2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3. (
. 02 . 03 . 04				0 0 0	0 0 0	3. ( 3. ( 3. (
. 05				0	0	3. (
50	Provider to Program ADJUSTMENTS TO PROGRAM	1		0	0	3.
50 51	ADJUSTINIENTS TO PROGRAM			0	0	3. 3.
. 52				0	0	3.
. 53				0	0	3.
. 54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		10, 682, 33	39	4, 293, 220	4.
00	List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		11, 5	76	22, 373	6.
02	SETTLEMENT TO PROGRAM			0	0	6.
00	Total Medicare program liability (see instructions)		10, 693, 9		4, 315, 593	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	0		1.00	2.00	8.

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVI EW	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet E- Part II Date/Time Pre 6/23/2020 1:2	epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1			-
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

	E SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 01/01/2019	Worksheet G	
ina-τ il y)	ype accounting records, complete the General Fund column			0 12/31/2019		
<u> </u>		General Fund	Speci fi c	Endowment Fund	6/23/2020 1:2 Plant Fund	8 pr
		1.00	Purpose Fund 2.00		4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	4, 643, 566	C	0	0	1
00	Temporary investments	C	C	0	0	
00	Notes receivable	0	C	0	0	
00	Accounts receivable	27, 339, 082	C	0	0	
00	Other receivable	0	0	0	0	
00	Allowances for uncollectible notes and accounts receivable Inventory			0	0	
00 00	Prepaid expenses	-2, 080, 472		0	0	
00	Other current assets	2,000,472		0	0	
. 00	Due from other funds		C C	Ő	0	
. 00	Total current assets (sum of lines 1-10)	29, 902, 176	C	0	0	
	FI XED ASSETS			· · · · ·		
. 00	Land	C	C	0	0	12
. 00	Land improvements	0	C	0	0	13
. 00	Accumulated depreciation	0	C	0	0	
. 00	Buildings	9, 446, 043	C	0	0	
. 00	Accumulated depreciation	-3, 346, 653		0	0	
. 00	Leasehold improvements Accumulated depreciation	6, 882, 938		0	0	
. 00 . 00	Fixed equipment	-3, 620, 389 157, 301		0	0	
0.00	Accumulated depreciation	-97, 186		0	0	
. 00	Automobiles and trucks	21, 045		0	0	
. 00	Accumulated depreciation	-21, 045		Ő	0	
. 00	Major movable equipment	29, 497, 083	C	0	0	
. 00	Accumulated depreciation	-16, 926, 850	C	0	0	24
. 00	Minor equipment depreciable	0	C	0	0	25
. 00	Accumulated depreciation	0	C	0	0	26
	HIT designated Assets	0	C	0	0	
. 00	Accumulated depreciation	0	C	0	0	
. 00	Minor equipment-nondepreciable	0	C	-	0	
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	21, 992, 287	C	0	0	30
. 00	Investments	0	C	ol	0	3.
. 00	Deposits on Leases			0	0	
. 00	Due from owners/officers		C C	0	0	
. 00	Other assets	57, 163, 144	c	0	0	
. 00	Total other assets (sum of lines 31-34)	57, 163, 144		0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	109, 057, 607	C	0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	8, 040, 184		0	0	
. 00	Salaries, wages, and fees payable	1, 574, 125	C	0	0	
. 00	Payroll taxes payable			0	0	
	Notes and loans payable (short term)	615, 851		0	0	1
. 00	Deferred income Accelerated payments			0	0	41
. 00	Due to other funds			0	0	
. 00	Other current liabilities	466, 889		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	10, 697, 049		-	0	
	LONG TERM LI ABI LI TI ES					
. 00	Mortgage payable	0	C	0	0	46
. 00	Notes payable	0	C	0	0	47
. 00	Unsecured Loans	0	C	0	0	
. 00	Other long term liabilities	3, 381, 825		0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	3, 381, 825			0	
. 00	Total liabilities (sum of lines 45 and 50)	14, 078, 874	C	0	0	5
00	CAPITAL ACCOUNTS	04 070 700		I		- -
. 00 . 00	General fund balance Specific purpose fund	94, 978, 733	c c			52
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - restricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
-	replacement, and expansion				-	
00	Total fund balances (sum of lines 52 thru 58)	94, 978, 733	C	0	0	59
. 00						

Heal th	Financial Systems 0	RTHOPAEDIC HOSP	T. AT PARKVI EW		In	Lieu of Form CMS-	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0167	Period: From 01/01/20 To 12/31/20	Worksheet G-1	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 442,605,803	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		87, 350, 716			-	2.00
3.00 4.00	Total (sum of line 1 and line 2) ADDITONS TO FUND BALANCE	0	529, 956, 519		0	0	3.00 4.00
5.00	ADDITIONS TO FOND DALANCE	0			0	0	
6.00 7.00		0			0	C	
7.00 8.00		0			0		
9.00		0			0	0	
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 529, 956, 519			0	10.00
12.00	DEDUCTIONS TRANSFERS FROM FUND BAL	436, 100, 000	327, 730, 317		0	C C	
13.00 14.00		0			0	C	
14.00 15.00		0			0		
16.00		0			0	C	
17.00 18.00	Total deductions (sum of lines 12–17)	0	436, 100, 000		0	C	17.00 18.00
19.00	Fund balance at end of period per balance		93, 856, 519			0	19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00 4.00	Total (sum of line 1 and line 2) ADDITONS TO FUND BALANCE	0	0		0		3.00
5.00	ADDITIONS TO FOND BALANCE		0				5.00
6.00 7.00			0				6.00 7.00
7.00 8.00			0				8.00
9.00			0				9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10.00
12.00	DEDUCTIONS TRANSFERS FROM FUND BAL		0				12.00
13.00 14.00			0				13.00
15.00			0				15.00
16. 00 17. 00			0				16.00 17.00
17.00	Total deductions (sum of lines 12–17)	0	0		0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0167		riod: om 01/01/2019 12/31/2019	Worksheet G-2 Parts I & II Date/Time Pre	pared:
	Cost Center Description		Inpatient		Outpati ent	6/23/2020 1:2 Total	8 pm
	cost center bescription		1.00		2.00	3.00	
	PART I – PATIENT REVENUES		1.00		2.00	0.00	
	General Inpatient Routine Services						1
1.00	Hospi tal		7, 205, 9	29		7, 205, 929	1.0
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	5.0
6.00	Swing bed - NF			0		0	6.0
7.00	SKILLED NURSING FACILITY						7.0
8.00	NURSING FACILITY						8.0
9.00	OTHER LONG TERM CARE						9.0
10.00	Total general inpatient care services (sum of lines 1-9)		7, 205, 9	29		7, 205, 929	10.0
	Intensive Care Type Inpatient Hospital Services						
11.00	I NTENSI VE CARE UNI T						11.0
12.00	CORONARY CARE UNIT						12.0
13.00	BURN INTENSIVE CARE UNIT						13.0
14.00	SURGICAL INTENSIVE CARE UNIT						14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of	lines		0		0	16.0
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	)	7, 205, 9	29		7, 205, 929	17.0
18.00	Ancillary services		237, 567, 2	30	0	237, 567, 230	18.0
19.00	Outpatient services			0	181, 931, 947	181, 931, 947	19.0
20.00	RURAL HEALTH CLINIC			0	0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULANCE SERVICES						23.0
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0	95, 675, 797	95, 675, 797	
26.00	HOSPICE						26.0
27.00	PHYSI CAL THERAPY REVENUE			0	22, 109, 200	22, 109, 200	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	244, 773, 1	59	299, 716, 944	544, 490, 103	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				101, 704, 924		29.0
30.00	HOME OFFICE INTERST EXPENSE		1, 122, 2				30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				0	1 100 011		35.0
36.00	Total additions (sum of lines 30-35)			_	1, 122, 214		36.0
37.00	DEDUCT (SPECI FY)			0			37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00				0	_		41.0
42.00	Total deductions (sum of lines 37-41)				0		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		1	102, 827, 138		43.0

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
		Peri od:	Worksheet G-3		
			From 01/01/2019 To 12/31/2019	Date/Time Pre	arod
			10 12/31/2019	6/23/2020 1:2	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		544, 490, 103	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		355, 133, 965	2.00
3.00	Net patient revenues (line 1 minus line 2)			189, 356, 138	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		102, 827, 138	4.00
5.00	Net income from service to patients (line 3 minus line 4)			86, 529, 000	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			1, 791	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			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	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	nan patients		5, 215	
	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
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00 20.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			0	20.00
21.00 22.00	Rental of hospital space			116, 369	
22.00	Governmental appropriations			110, 309	22.00
23.00	OTHER OPERATING REVENUE			687, 746	
24.00	Total other income (sum of lines 6-24)			811, 121	24.00 25.00
26.00	Total (line 5 plus line 25)			87, 340, 121	26.00
20.00	LOSS ON SALE OF ASSET			-10, 595	
27.00	Total other expenses (sum of line 27 and subscripts)			-10, 595	
	00 Net income (or loss) for the period (line 26 minus line 28)			87, 350, 716	
27.00	The thread of 1033/101 the period (thread all has the 20)		I	07, 330, 710	27.00

leal th	Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		F	Provider CCN: 15-0167	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre 6/23/2020 1:23	
			Title XVIII	Hospi tal	PPS	
					1.00	
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
	Capital DRG other than outlier				878, 098	
	Model 4 BPCI Capital DRG other than outlier				0	
2.00	Capital DRG outlier payments				184	2.00
2.01					0	2.01
3.00					12.53	•
4.00				0.00		
	Indirect medical education percentage				0.00	
5.00	Indirect medical education adjustment 1.01)(see instructions)	(multiply line 5 by the s	um of lines 1 and 1.01	, columns 1 and	0	6.00
7.00	Percentage of SSI recipient patient da 30) (see instructions)	ys to Medicare Part A pat	ient days (Worksheet E	, part A line	0.00	7.00
B. 00	Percentage of Medicaid patient days to total days (see instructions)				0.00	8.00
9.00	Sum of Lines 7 and 8			0.00	9.00	
10.00	Allowable disproportionate share perce	ntage (see instructions)			0.00	10.00
11.00	Disproportionate share adjustment (see	instructions)			0	11.00
12.00	Total prospective capital payments (se				878, 282	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year	0	11.00
	Worksheet L, Part III, line 14)		
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
40.00			10.00

13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00
	(if line 12 is negative, enter the amount on this line)		
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00