Health Financia	al Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2552-10				
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPRO									
payments made	since the beginning of the co	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150167 Period: Work AND SETTLEMENT SUMMARY Pariod: Provider CCN: 150167 Period: Provider CCN: 150167 Provider CCN: 1									
PART I - COST	REPORT STATUS				5/29/2015 7:35 am				
Provi der	1. [X] Electronically filed	cost report		Date: 5/29/20	015 Time: 7:35 am				
use only	2. [] Manually submitted co	ost report							
	3. [0] If this is an amended 4. [F] Medicare Utilization.	I report enter the number of Enter "F" for full or "L"	times the provide for low.	r resubmitted this c	ost report				
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN						

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ORTHOPAEDIC HOSPT. AT PARKVIEW (150167) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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	Officer or Administrator of Provider(s)
Title	2
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			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	-285	28, 826	16, 281	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	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	-285	28, 826	16, 281	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.

18.00 Renal Dialysis 18. 19.00 Other 19.
20.00 Cost Reporting Period (mm/dd/yyyy) 21.00 Type of Control (see instructions) 1.00 2.00 21.00 Type of Control (see instructions) 1.00 1/01/2014 20. 21.00 Dose this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c) (2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 2, "Y" for he portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for the portion of the cost reporting period on prior to October 1. Enter in column 2, "Y" for the portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for he portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for he portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for he portion of the cost reporting period on or after October 1. Enter in column 2, "Y" for he portion of the cost reporting period on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.
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of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the
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42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23. 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23. 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the
1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the
used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.
In-State In-State Out-of Medicaid Other

17.00

Medi cai d HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days el i gi bl e unpai d days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 180 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

Medi cai d

State

State

17.00 Hospital -Based (CMHC) I

	Financial Systems ORTHOPAED AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		PT. AT PARKVI EW Provi der		Period: From 01/01 To 12/31	/2014 /2014	Workshe Part I Date/Ti 5/29/20	eet S-2 me Pre 015 7:3	epared: 34 am
					Urban/Ru 1.00		Date of 2.0		
26. 00	Enter your standard geographic classification (not wa	ge) sta	atus at the beg	inning of the		1	2. (<i>.</i>	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	ge) sta "2" fo	atus at the end or rural. If ap			1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the			H status in		О			35. 00
	effect in the cost reporting period.				Begi nni	i na:	Endi	na	
					1. 00		2. (1
36. 00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	-				36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		О			37. 00
38 00	in effect in the cost reporting period. Enter applicable beginning and ending dates of MDH st	atus 9	Subscript line	38 for number	-				38. 00
36.00	of periods in excess of one and enter subsequent date		subscript iiile	36 FOI Hulliber					36.00
					Y/N		Υ/		
39 00	Does this facility qualify for the inpatient hospital	navmer	nt adjustment f	or Low volume	1. 00 e Y	0	2. (N		39. 00
37.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente uiremen	er in column 1 nts in accordan	"Y" for yes ce with 42					37.00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adj us [.] er 1. l	tment? Enter "Y Enter "Y" for y	" for yes or	- N		N		40. 00
		,	3.13,		<u> </u>	V	XVIII	XIX	
	Drannative Downent Cystem (DDC) Canital					1.00	2. 00	3.00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for o	di sproporti onat	e share in ac	ccordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46. 00
47. 00	Is this a new hospital under 42 CFR §412.300 PPS capi	tal? I	Enter "Y for ye	s or "N" for	no.	N	N	N	47. 00
48. 00	Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no).	N	N	N	48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56. 00
	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	yes o	r "N" for no in	column 1. If	column 1	N			57. 00
	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	", com	plete Worksheet						
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, § 2148? If yes, complete Wk			ns' services	as	N			58. 00
	Are costs claimed on line 100 of Worksheet A? If yes					N			59. 00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60.00
	provider-operated criteria dider 3413.63: Effer i	Y/N	IME	Direct GME	I ME		Di rect	GME	
		1.00	2.00	2.00	4.0	0	F (20	-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1. 00 N	2. 00	3. 00	4.0	0.00	5. (61.00
	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0.0	00				61. 01
(1.00	ending and submitted before March 23, 2010. (see instructions)								/1 00
	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		0.00	0. (JU				61. 02
	ACA). (see instructions) 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		0.00	0.0	00				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	oo				61. 04
61. 05	current cost reporting period. (see instructions). 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		0.00	0. 0	00				61. 05
	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being		0.00	0. (61.06

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE		OI C HOSPT. AT			Period: From 01/01/2014	worksheet S-2 Part I	
		Progran	n Name		To 12/31/2014 e Unweighted IME	5/29/2015 7:3	pared: 4 am
					FTE Count	Direct GME FTE Count	
		1. 0	00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specialty, if any, and the for each new program. (see column 1, the program name, program code, enter in coluunweighted count and enter FTE unweighted count. 61.20 Of the FTEs in line 61.05, program specialty, if any, residents for each expanded instructions) Enter in coluenter in column 2, the program specialty.	number of FTE residents instructions) Enter in enter in column 2, the mn 3, the IME FTE in column 4, direct GME specify each expanded and the number of FTE program. (see mn 1, the program name, ram code, enter in column				0. 00		61. 10
 the IME FTE unweighted c direct GME FTE unweighte 							
					·	1. 00	
ACA Provisions Affecting th 62.00 Enter the number of FTE res					ried for which	0.00	62. 00
your hospital received HRSA 62.01 Enter the number of FTE res	PCRE funding (see instructions idents that rotated from a	ctions) a Teaching H	ealth Cent	ter (THC) int			62. 01
during in this cost reporti Teaching Hospitals that Cla			nstructi or	ns)			
63.00 Has your facility trained r	esidents in nonprovider se	ettings duri				N	63. 00
				Unwei ghted		Ratio (col. 1/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te		//	
C 11 FF04 C 11 A0A B	V FTF D : I I : N			1.00	2.00	3.00	
Section 5504 of the ACA Bas period that begins on or af				inis base yea	r is your cost i	reporting	
64.00 Enter in column 1, if line in the base year period, th resident FTEs attributable settings. Enter in column resident FTEs that trained of (column 1 divided by (co	63 is yes, or your facilit e number of unweighted nor to rotations occurring in 2 the number of unweighted in your hospital. Enter in	ty trained r n-primary ca all nonprov d non-primar n column 3 t	esidents re ider y care he ratio	0. (0. 00	0. 000000	64. 00
	Program Name	Progran	n Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line is yes, or your facility trained residents in the ba year period, the program na associated with primary care FTEs for each primary care program in which you traine residents. Enter in column the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to	se me e d 2,			0. (0.00	0. 000000	65.00

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)

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/	2014	Worksheet Part I	l 3-2	
			To 12/31/		Date/Ti me 5/29/2015		
			V 1. 00		XI X 2. 00		
Title V and XIX Services			1.00		2.00		
00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	tal services? Ei	nter "Y" for	N		Y	'	90.
00 Is this hospital reimbursed for title V and/or XIX through			N		N		91.
full or in part? Enter "Y" for yes or "N" for no in the app 00 Are title XIX NF patients occupying title XVIII SNF beds (c	dual certificati				N		92.
instructions) Enter "Y" for yes or "N" for no in the applic 00 Does this facility operate an ICF/MR facility for purposes		XIX? Enter	N		N		93.
"Y" for yes or "N" for no in the applicable column.							
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N		N	'	94
00 If line 94 is "Y", enter the reduction percentage in the ap 00 Does title V or XIX reduce operating cost? Enter "Y" for ye			N	0. 00	N	0.00	95 96
applicable column.	25 OF IN TOT 110	o ili tile	IN IN		IN.		
00 If line 96 is "Y", enter the reduction percentage in the ap	oplicable column	า.		0. 00		0. 00	97
5.00 Does this hospital qualify as a Critical Access Hospital (C			N	T			05
6.00 f this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	nod of paymen	t			1	106
.00 Column 1: If this facility qualifies as a CAH, is it eligi	ble for cost re	eimbursement				10	107
for I &R training programs? Enter "Y" for yes or "N" for rinstructions) If yes, the GME elimination would not be on W							
the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educ							
CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or			е				
instructions) 3.00 s this a rural hospital qualifying for an exception to the	e CRNA fee sche	dul e? See 42	N			10	108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	Speech	n	Respi rat	tory	
	1.00	2.00	3.00		4. 00		
0.00 If this hospital qualifies as a CAH or a cost provider, are	e N					111	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	s IV				1 00		09
for yes or "N" for no for each therapy. O.00 Did this hospital participate in the Rural Community Hospit	cal Demonstratio	on project (4	10A Demo)for	-	1. 00 N		
for yes or "N" for no for each therapy.	cal Demonstratio	on project (4	10A Demo)for	1. 00	N		110
for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information	cal Demonstration		,	1. 00	N	3.00	110
for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information Dis this an all-inclusive rate provider? Enter "Y" for yes on is yes, enter the method used (A, B, or E only) in column 2	cal Demonstration for no. or "N" for no in for lift column 2 in	n column 1. lis "E", enter	f column 1		N	3.00	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or	cal Demonstration for no. or "N" for no in the column 2 is the column 2 is the column 4 the col	n column 1. I is "E", enter rm care (incl	f column 1 in column udes	1. 00	N	3.00	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes on its yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, §2208.1.	cal Demonstration for no.	n column 1. I is "E", enter rm care (incli ne definition	f column 1 in column udes	1. 00 N	N	3.00	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, §2208.1. D. 00 Is this facility classified as a referral center? Enter "Y"	cal Demonstration for no.	n column 1. In sis "E", enter rm care (inclume definition for no.	f column 1 in column udes in CMS	1. 00	N	3.00	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" to this facility legally-required to carry malpractice insurance.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. In is "E", enter rm care (include definition of the form of the fo	f column 1 in column udes in CMS	1. 00 N	N	3.00	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" to this facility legally-required to carry malpractice insurance.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. It is "E", enter rm care (include definition of the form of the policy	f column 1 in column udes in CMS	1. 00 N N Y	N 2.00 3	3.00 0 1	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 is either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" only in this facility legally-required to carry malpractice insurance. B. 00 Is the malpractice insurance a claims-made or occurrence possible.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. In is "E", enter rm care (include definition of the form of the fo	f column 1 in column udes in CMS	1. 00 N N Y	N	3.00 0 1	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or "syes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, \$2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" to 00 Is this facility legally-required to carry malpractice insurance. B. 00 Is the malpractice insurance a claims-made or occurrence possible.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. It is "E", enter rm care (include definition of the form of the policy	f column 1 in column udes in CMS	1. 00 N N Y	N 2.00 3	3.00 0 1	110
for yes or "N" for no for each therapy. Dool Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information Dool Is this an all-inclusive rate provider? Enter "Y" for yes or "syes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. Dool Is this facility classified as a referral center? Enter "Y" to soll is this facility legally-required to carry malpractice insurance. Dool Is the malpractice insurance a claims-made or occurrence positive states.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. It is "E", enter rm care (include definition of the definition of the policy of the poli	f column 1 in column udes in CMS "N" for is Losses	1. 00 N N Y	N 2.00 3	3.00 0 1 1 1 1 1	110
for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information Disthis an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. Dols this facility classified as a referral center? Enter "Y" on is this facility legally-required to carry malpractice insurance. Disthe malpractice insurance a claims-made or occurrence pocciaim-made. Enter 2 if the policy is occurrence.	cal Demonstration for no. or "N" for no in the control of the control of the cars, based on the cars, based	n column 1. It is "E", enter rm care (included definition of the form of the policy of	f column 1 in column udes in CMS "N" for is Losses	1. 00 N N Y	N 2.00 3	3.00 0 1 1 1 1 1	110
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, \$2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" on the collistic of the malpractice insurance as a claims-made or occurrence position. D. 00 Is the malpractice insurance a claims-made or occurrence position. D. 01 Is the malpractice insurance as claims-made or occurrence position. D. 02 Is the malpractice insurance as claims-made or occurrence position. D. 03 Is the malpractice insurance as claims-made or occurrence position. D. 04 List amounts of malpractice premiums and paid losses:	cal Demonstration for no. or "N" for no in 2. If column 2 in the for long tears of the cars of the ca	r column 1. It is "E", enter rm care (include definition of the policy o	f column 1 in column udes in CMS "N" for is Losses 2.00	1.00 N N Y 1	N 2.00 3	1 3.00 0 1 1 1 1 1 1 1 nce	110 115 118
for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D. 00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, \$2208. 1. D. 00 Is this facility classified as a referral center? Enter "Y" on this facility legally-required to carry malpractice insurance. D. 00 Is the malpractice insurance a claims-made or occurrence post claim-made. Enter 2 if the policy is occurrence.	cal Demonstration for no. or "N" for no in the control of the con	r column 1. It is "E", enter rm care (include definition of the policy o	f column 1 in column udes in CMS "N" for is Losses 2.00	1.00 N N Y 1	1 nsuran	1 3.00 0 1 1 1 1 1 1 1 nce	110 115 118
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for yes or "N" for no for each therapy. Do this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information Do this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percet psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208. 1. Do this facility classified as a referral center? Enter "Y" to this facility legally-required to carry malpractice insurance. B. 00 Is the malpractice insurance a claims-made or occurrence poclaim-made. Enter 2 if the policy is occurrence. B. 01 List amounts of malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein. D. 00 NOT USE THIS LINE D. 00 Is this a SCH or EACH that qualifies for the Outpatient Holes \$3121 and applicable amendments? (see instructions) Enter is	cal Demonstration for no. or "N" for no in 2. If column 2 is ent for long tears) based on the case of	n column 1. It is "E", enter rm care (include definition of the policy o	f column 1 in column udes in CMS "N" for is Losses 2.00 00 1.00	1.00 N N Y 1	I nsuran 3.00	1 3.00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 118 118
for yes or "N" for no for each therapy. Do this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information Do this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, \$2208. 1. Do ls this facility classified as a referral center? Enter "Y" to list his facility legally-required to carry malpractice insurance. B. 00 Is the malpractice insurance a claims-made or occurrence posterial members. B. 01 List amounts of malpractice premiums and paid losses: Administrative and General? If yes, submit supporting sche and amounts contained therein. Do Do NoT USE THIS LINE.	cal Demonstration for no. or "N" for no in 2. If column 2 is ent for long tears) based on the case of	r column 1. It is "E", enter m care (included definition of the policy o	f column 1 in column udes in CMS "N" for is Losses 2.00 00 1.00	1.00 N N Y 1	I nsuran 3.00	1 3.00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110
for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. D.00 Is this facility classified as a referral center? Enter "Y" only this facility legally-required to carry malpractice insurance. D.00 Is the malpractice insurance a claims-made or occurrence post claim-made. Enter 2 if the policy is occurrence. D.00 Is the malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. D.00 NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Holes §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no.	cal Demonstration for no. or "N" for no in the control of the care of the car	n column 1. It is "E", enter m care (included finition of the definition of the definition of the policy of the po	f column 1 in column udes in CMS "N" for is Losses 2.00 N	1.00 N N Y 1	I nsuran 3.00	1 3.00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 116 117 118 118
for yes or "N" for no for each therapy. Doo Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"	cal Demonstration for no. or "N" for no in the control of the care of the car	n column 1. It is "E", enter m care (included finition of the definition of the definition of the policy of the po	f column 1 in column udes in CMS "N" for is Losses 2.00 00 1.00	1.00 N N Y 1	I nsuran 3.00	1 3.00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 116 117 118 118
for yes or "N" for no for each therapy. 1.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" 1.00 Dis this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percepsychiatric, rehabilitation and long term hospitals provide Pub. 15-1, \$2208.1. 1.00 Dis this facility classified as a referral center? Enter "Y" only this facility legally-required to carry malpractice insurance. 1.00 Dis the malpractice insurance a claims-made or occurrence poclaim-made. Enter 2 if the policy is occurrence. 1.01 List amounts of malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 1.00 Do NOT USE THIS LINE 1.00 Dis this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA \$3121 and applicable amendmenter Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 1.01 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no.	cal Demonstration for no. or "N" for no in 2. If column 2 is ent for long tears) based on the care ba	n column 1. It is "E", enter m care (incline definition of for no. Y" for no. Y" for yes or of the policy Premiums 1.00 49,33 than the post centers Vision in ACA of for yes or ne Outpatient ructions) s charged to	F column 1 in column udes in CMS "N" for is Losses 2.00 N N	1.00 N N Y 1	I nsuran 3.00	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 118 118 118
for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information D.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "see, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percepsychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. D.00 Is this facility classified as a referral center? Enter "Y" on this facility legally-required to carry malpractice insurance. B.00 Is the malpractice insurance a claims-made or occurrence pocal claim-made. Enter 2 if the policy is occurrence. B.01 List amounts of malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. D.00 DO NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that cheld Harmless provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. D.00 Dot this facility incur and report costs for high cost implications. D.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	cal Demonstration for no. or "N" for no in 2. If column 2 is ent for long telers) based on the care b	n column 1. It is "E", enter m care (included definition of the definition of the definition of the policy of the	f column 1 in column udes in CMS "N" for is Losses 2.00 N	1.00 N N Y 1	I nsuran 3.00	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 118 118 118 120
for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, \$2208.1. B.00 Is this facility classified as a referral center? Enter "Y" to lis this facility legally-required to carry malpractice insumo. B.00 Is the malpractice insurance a claims-made or occurrence policial memade. Enter 2 if the policy is occurrence. B.01 List amounts of malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemal amounts contained therein. D.00 NOT USE THIS LINE D.00 Is this a SCH or EACH that qualifies for the Outpatient Holes S121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that the Hold Harmless provision in ACA \$3121 and applicable amendments. In this a rural hospital with < 100 beds that the Hold Harmless provision in ACA \$3121 and applicable amendments. In this account of the patients? Enter "Y" for yes or "N" for no. Transplant Center Information B.00 Does this facility operate a transplant center? Enter "Y" for yes or "N" for no.	cal Demonstration for no. or "N" for no in 2. If column 2 is ent for long tears) based on the cars ba	n column 1. It is "E", enter m care (included definition of the definition of the definition of the policy of the	F column 1 in column udes in CMS "N" for is Losses 2.00 N N	1.00 N N Y 1	I nsuran 3.00	0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	110 115 118 118 118

Health Financial Systems	ORTHOPAEDIC HOS	SPT. AT PARKVIEW		In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der 0		eriod: rom 01/01/2014	Worksheet S- Part I	-2
				o 12/31/2014	Date/Time Pr	
					5/29/2015 7:	34 am
128.00 If this is a Medicare certified li	vor transplant contor o	ntor the cortific	nation data	1. 00	2.00	128. 00
in column 1 and termination date,	if applicable, in column	2.				
129.00 If this is a Medicare certified Lucolumn 1 and termination date, if		ter the certifica	ation date in			129. 00
130.00 If this is a Medicare certified pa	increas transplant center		ification			130. 00
131.00 If this is a Medicare certified in date in column 1 and termination of	ntestinal transplant cent	er, enter the ce	rti fi cati on			131. 00
132.00 If this is a Medicare certified is	slet transplant center, e	nter the certifi	cation date			132. 00
in column 1 and termination date, 133.00 f this is a Medicare certified of	her transplant center, e	nter the certifi	cation date			133. 00
in column 1 and termination date, 134.00 If this is an organ procurement or and termination date, if applicabl	ganization (OPO), enter		n column 1			134. 00
All Providers 140.00 Are there any related organization	or home office costs as	defined in CMS I	Pub. 15-1.	Y	15H032	140. 00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. I	f yes, and home of	office costs			
1.00	2.	00		3.00		
If this facility is part of a chai home office and enter the home off	9		•	me and address	of the	
141. 00 Name: PARKVIEW HEALTH SYSTEM, INC	C. Contractor's Name: W	/ISCONSIN PHYSICI		's Number: 8		141. 00
142.00Street: 10501 CORPORATE DRIVE		SERVI CE 5600				142. 00
143.00 City: FORT WAYNE	State: I	N	Zi p Code:	4689	95-5600	143. 00
					1.00	_
144.00 Are provider based physicians' cos			noto for inno	tiont complete	N	144. 00
145.00 If costs for renal services are clonly? Enter "Y" for yes or "N" for		ne 74, are the co	osts for Tripa		N	145. 00
				1. 00	2. 00	_
146.00 Has the cost allocation methodolog				N N	2.00	146. 00
Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in		15-2, § 4020) I	f yes, enter			
147.00 Was there a change in the statisti	cal basis? Enter "Y" for			N		147. 00
148.00Was there a change in the order of 149.00Was there a change to the simplifi				N N		148. 00 149. 00
no.		Part A	Part B	Title V	Title XIX	
Deep this facility contains a gravit		1.00	2.00	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '						
155.00Hospi tal 156.00Subprovi der – TPF		N N	N N	N N	N N	155. 00
157. 00 Subprovi der – TRF		N N	N	N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER		N	N	N.	N	158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161. 00 CMHC			N	N	N	161. 00
					1.00	
Multicampus 165.00 s this hospital part of a Multica	ampus hospital that has o	ne or more campus	ses in differe	ent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1. 00		00 4.00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in					0.0	00 166. 00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						
					1.00	
Health Information Technology (HI					1.00	
167.00 s this provider a meaningful user	under Section §1886(n)?	Enter "Y" for	yes or "N" fo	no.	Y	167. 00
168.00 f this provider is a CAH (line 10 reasonable cost incurred for the H			10/ 15 Y),	enter the		0168. 00
169.00 If this provider is a meaningful utransition factor. (see instruction		d is not a CAH (line 105 is "1	N"), enter the	0. !	50169. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	DENTIFICATION DATA	Provi der CCN: 150167	Peri od:	Worksheet S-2	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/29/2015 7:3	
					4 am
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beging period respectively (mm/dd/yyyy)	170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2013				170. 00
				1.00	
171.00 If line 167 is "Y", does this provide				N	171. 00
Medicare cost plans reported on Wkst. (see instructions)	S-3, Pt. I, Tine 2, col. 6	o? Enter "Y" for yes an	a "N" For no.		

		RTHOPAEDIC HOSPT. AT				eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2014 To 12/31/2014		epared:
					Y/N	Date	J4 alli
	General Instruction: Enter Y for all YES resp	onses. Enter N for	all NO re	esponses. Ente	1.00 r all dates in	2.00 the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS						
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the beg	inning of	the cost	N		1.0
	reporting period? If yes, enter the date of t	the change in colum	n 2. (see	instructions) Y/N	Date	V/I	
				1.00	2. 00	3.00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			N			2.0
3. 00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, chain home offic d to the provider o , or members of th	es, drug r its e board	N			3. 00
				Y/N	Type	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Center date availab	ompiled,	N			4. 00
5. 00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total those on the filed financial statements? If y	revenues different		N			5. 0
					Y/N 1. 00	Legal Oper. 2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N		6.0
7 00	the legal operator of the program?) f	oti ono	·	N		7.0
7. 00 8. 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/		d during the	N N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		urrent cos	st report? If	N		9. 0
10. 00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the	current o	cost reporting	N		10.00
11. 00	period? If yes, see instructions. Are GME cost directly assigned to cost center		in an App	proved	N		11. 0
	Teaching Program on Worksheet A? If yes, see	i nstructi ons.				Y/N 1.00	
12 00	Bad Debts Is the provider seeking reimbursement for bac	1 dobte2 lf vos so	n instruct	tions		Y	12. 0
	If line 12 is yes, did the provider's bad det period? If yes, submit copy.				st reporting	N	13. 0
14. 00	1.	and/or co-payments	waived? If	yes, see ins	tructi ons.	N	14. 0
15. 00	Did total beds available change from the price	or cost reporting p	eriod? If	f		N	15. 0
		Descriptio	n	Y/N	rt A Date	Part B Y/N	
	loop p	0		1.00	2. 00	3. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,			N		N	16. 0
	enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)						
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		N	17. 0
18. 00	yes, enter the paid-through date 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			Y		Y	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of			N		N	19. 00
20. 00	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe			N		N	20.00

Health Financial Systems C	ORTHOPAEDIC HOSPT.AT	PARKVI EW		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der	CCN: 150167	From 01/01/2014	Worksheet S-2 Part II Date/Time Pre 5/29/2015 7:3	pared:
			P	art A	Part B	
	Descriptio	n	Y/N	Date	Y/N	
	0		1.00	2. 00	3.00	

				1	o 12/31/2014	Date/Time Pro 5/29/2015 7:3	
				Par	-t A	Part B	J4 alli
		Descr	iption	Y/N	Date	Y/N	
			0	1.00	2. 00	3. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21. 00
	COMPLETED BY COCT DELMBURGED AND TEEDA HOCDLY	TALC ONLY (EVO	FDT CHILL DDENC H	OCDLTALC)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS UNLY (EXC	EPT CHILDRENS H	USPITALS)			-
22. 00	Have assets been relifed for Medicare purpose	es? If ves se	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreci			als made durir	g the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new lesses and/or amendments to existing	g Leases enter	red into during	this cost repo	orting period?		24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entere	ed into during	the cost repor	ting period? I	f yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acqu	uired during t	he cost reporti	ng period? If	yes, see		26. 00
27. 00	<pre>instructions. Has the provider's capitalization policy char copy.</pre>	nged during th	ne cost reportin	g period? If y	ves, submit		27. 00
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit e	entered into dur	ing the cost r	eporti ng	N	28. 00
29. 00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			bt Service Res	erve Fund)	N	29. 00
30. 00	Has existing debt been replaced prior to its instructions.			debt? If yes,	see	N	30. 00
31. 00	Has debt been recalled before scheduled matur instructions.	ity without i	ssuance of new	debt? If yes,	see	N	31. 00
	Purchased Services						
32. 00	Have changes or new agreements occurred in pa			d through cont	ractual	N	32. 00
33. 00	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S no, see instructions.			g to competiti	ve bidding? If		33. 00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an a	rrangement with	provi der-base	ed physicians?	N	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements			ts with the pr	ovi der-based		35. 00
	physicians during the cost reporting period?	If yes, see i	nstructions.		Y/N	Date	
					1.00	2. 00	
	Home Office Costs				1.00	2.00	
36.00	Were home office costs claimed on the cost re	eport?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost stallf yes, see instructions.	atement been p	prepared by the	home office?	Υ		37. 00
38. 00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the 1				N		38. 00
39. 00	If line 36 is yes, did the provider render se see instructions.				N		39. 00
40. 00	If line 36 is yes, did the provider render selinstructions.	ervices to the	e home office?	If yes, see	N		40. 00
			1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title		ERI C		NI CKESON		41. 00
40.00	held by the cost report preparer in columns of respectively.		DADKWI EW LIEAL T	II CVCTEM INO			42.00
42. 00	Enter the employer/company name of the cost r preparer.	•	PARKVI EW HEALT		EDIO NI OVEOC	24DIA4 E	42.00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective		(260) 373-8406		ERI C. NI CKESON@I	PARKVI EW. COM	43. 00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150167 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/29/2015 7:34 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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 instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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 cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DIRECTOR, REIMBURSEMENT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 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.

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 24/31/2014 | Part | Pa Health Financial Systems ORTHOPAED
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150167

					10	0 12/31/2014	5/29/2015 7:3	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	55p51.6172	Line Number		o. Bodo	Avai I abl e	57.11 1.15 G 1 5		
		1. 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		37	13, 505	0, 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				.,			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			37	13, 505	0.00	0	7.00
	beds) (see instructions)				.,			
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14.00	Total (see instructions)			37	13, 505	0.00	0	14.00
15.00	CAH visits				·		0	15. 00
16.00	SUBPROVIDER - IPF							16. 00
17.00	SUBPROVIDER - IRF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27.00	Total (sum of lines 14-26)			37				27. 00
28. 00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
	-		-					

Health Financial Systems ORTHOPAED
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150167

				'	0 12/31/2014	5/29/2015 7: 3	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	- Cam
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 705	171	5, 320			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)	1, 233	0				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	1 705	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 705	171	5, 320			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	1, 705	171	5, 320	0.00	128. 70	
15. 00	CAH visits	1,700	.,,	0,020	0.00	120.70	15. 00
16. 00	SUBPROVI DER - I PF	J	ŭ	Ĭ			16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	128. 70	
28. 00	Observation Bed Days		23	284			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			164			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days	이		I	I	I	33. 00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | Colored Table | To 12/2015 | Table | Tabl Provi der CCN: 150167

				10	12/31/2014	5/29/2015 7: 34	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
Component		Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00 Hospital Adults & Peds. (column 8 exclude Swing Bed, Observation Hospice days) (see instructions for the portion of LDP room available).	on Bed and for col. 2 ailable beds)		C		46	2, 194	1. 00
2.00 HMO and other (see instructions 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing I Hospital Adults & Peds. Swing I Total Adults and Peds. (exclude beds) (see instructions)	Bed SNF Bed NF			483	O		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY		0. 00	C	661	46	2, 194	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
23.00 AMBULATORY SURGICAL CENTER (D.1) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENT 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instance) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instance)	TER struction) tructions)	0. 00					23. 00 24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
32.01 Total ancillary labor & deliver outpatient days (see instruction 33.00 LTCH non-covered days							32. 01 33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

 PARKVIEW
 In Lieu of Form CMS-2552-10

 Provider CCN: 150167
 Period: From 01/01/2014 | From 01/2014 | To 12/31/2014 | Date/Time Prepared:
 Worksheet S-3 | Part II | Part II | Prepared:

					Т	o 12/31/2014	Date/Time Pre 5/29/2015 7:3	
		Worksheet A	Amount	Reclassi fi cati		Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col. 2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)		col . 4	COI . 3)	
	2007 11 11007 2071	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	11, 876, 228	6, 617, 184	18, 493, 412	665, 025. 00	27. 81	1.00
2 00	instructions)		C	0	C	0.00	0.00	2.00
2. 00	Non-physician anesthetist Part A		C	,		0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		C	0	C	0. 00	0. 00	3. 00
4. 00	B Physician-Part A -		C			0.00	0.00	4. 00
00	Admi ni strati ve		, and a second					
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		C	0	O C	0. 00 0. 00	l .	
6. 00	Non-physician-Part B		C			0.00		
7.00	Interns & residents (in an	21. 00	C	0	o c	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		C			0.00	0.00	7. 01
7.01	residents (in an approved					0.00	0.00	7.01
8. 00	programs) Home office personnel		C	4, 407, 103	4, 407, 103	163, 884. 00	26. 89	8.00
9. 00	SNF	44. 00	C	0	4, 407, 103	0.00		
10.00	Excluded area salaries (see		3, 774, 009	-56, 780	3, 717, 229	132, 296. 00	28. 10	10. 00
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient		C	0	C	0.00	0.00	11. 00
12 00	Carte		C			0.00	0.00	12. 00
12. 00	Contract Labor: Top Level management and other		C	,		0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		C			0.00	0.00	13. 00
13.00	A - Administrative		C	ĺ		0.00		
14. 00	Home office salaries &		C	4, 407, 103	4, 407, 103	163, 884. 00	26. 89	14. 00
15. 00	wage-related costs Home office: Physician Part A		C	0	c	0.00	0. 00	15. 00
47.00	- Administrative					0.00		47.00
16. 00	Home office and Contract Physicians Part A - Teaching		C	,		0.00	0.00	16. 00
	WAGE-RELATED COSTS						i	
17. 00	Wage-related costs (core) (see instructions)		5, 179, 210	0	5, 179, 210			17. 00
18. 00	Wage-related costs (other)		C	0	o c			18. 00
19. 00	(see instructions) Excluded areas		1, 141, 832	0	1, 141, 832			19. 00
20.00	Non-physician anesthetist Part		1, 141, 632 C	0	1, 141, 632			20.00
04.00	A							
21. 00	Non-physician anesthetist Part		C					21.00
22. 00	Physician Part A -		C	0	o c			22. 00
22. 01	Administrative Physician Part A - Teaching		C		0			22. 01
23. 00	Physician Part B		C	_	ď			23. 00
24. 00	Wage-related costs (RHC/FQHC)		C	0	C			24.00
25. 00	Interns & residents (in an approved program)		C	0	C			25. 00
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	1, 494, 617 627, 008					
28. 00	Administrative & General under	3.00	027,000	0 3, 102, 017	3, 727, 023	0.00		
00.00	contract (see inst.)					0.00		00.00
29. 00 30. 00	Maintenance & Repairs Operation of Plant	6. 00 7. 00	127, 069	272, 571	399, 640	0. 00 16, 982. 00		
31. 00	Laundry & Linen Service	8. 00	.27,007	0	C	0.00	0. 00	31. 00
32.00	Housekeepi ng	9. 00	C	,	294, 197			
33. 00	Housekeeping under contract (see instructions)		C	,		0.00	0.00	33. 00
34. 00	Di etary	10. 00	C	203, 091	203, 091	5, 912. 00		
35. 00	Di etary under contract (see instructions)		C	0	'l C	0.00	0. 00	35. 00
36. 00	Cafeteri a	11. 00	C		d	0.00		
37.00	Maintenance of Personnel	12. 00 12. 00	C	0	C	0.00		37.00
38. 00 39. 00	Nursing Administration Central Services and Supply	13. 00 14. 00	C	27, 027	27, 027	0. 00 787. 00		38. 00 39. 00
40. 00	1 3	15. 00	C	•				40. 00

Heal t	h Financial Systems	OF	RTHOPAEDIC HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provi der	CCN: 150167 I	Peri od:	Worksheet S-3	
						From 01/01/2014	Part II	
					-	To 12/31/2014		
							5/29/2015 7: 3	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
41.00	Medical Records & Medical	16. 00	0	0		0.00	0. 00	41. 00
	Records Li brary							
42.00	Social Service	17. 00	143, 910	0	143, 910	5, 868. 00	24. 52	42.00
43.00	Other General Service	18. 00	0	0		0.00	0. 00	43.00

Heal th	Financial Systems	0	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Li€	eu of Form CMS-2	2552-10
HOSPI T	TAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014		
		Worksheet A		Recl assi fi cati	,		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1.00	2.00	3.00	4.00	5, 00	6, 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1. 00	Net salaries (see instructions)		11, 876, 228	2, 210, 081	14, 086, 30	9 501, 141. 00	28. 11	1. 00
2. 00	Excluded area salaries (see instructions)		3, 774, 009	-56, 780	3, 717, 22	9 132, 296. 00	28. 10	2. 00
3. 00	Subtotal salaries (line 1 minus line 2)		8, 102, 219	2, 266, 861	10, 369, 08	0 368, 845. 00	28. 11	3. 00
4. 00	Subtotal other wages & related costs (see inst.)		0	4, 407, 103	4, 407, 10	3 163, 884. 00	26. 89	4. 00
5. 00	Subtotal wage-related costs (see inst.)		5, 179, 210	0	5, 179, 21	0.00	49. 95	5. 00
/ 00	Total (our of lines 2 thru E)		12 201 420	/ /72 0/4	10 055 20	2 522 720 00		4 00

19, 955, 393 6, 821, 020

6, 673, 964 4, 428, 416

532, 729. 00

238, 648. 00

37. 46

28. 58

6. 00

7.00

13, 281, 429 2, 392, 604

6. 00

7.00

Total (sum of lines 3 thru 5)
Total overhead cost (see

instructions)

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 150167		Worksheet S-3
		From 01/01/2014 To 12/31/2014	Part IV Date/Time Prenared

		То	12/31/2014	Date/Time Prep 5/29/2015 7:34			
				Amount			
				Reported			
				1. 00			
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETI REMENT COST						
1.00	401K Employer Contributions			0	1. 00		
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			380, 560	2. 00		
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			675, 776			
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00				
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)						
5.00	401K/TSA Plan Administration fees			0	5. 00		
6.00	Legal/Accounting/Management Fees-Pension Plan			0	6. 00		
7.00	Employee Managed Care Program Administration Fees			65, 510	7. 00		
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)			3, 373, 582			
9.00	Prescription Drug Plan			0	9. 00		
10.00	Dental, Hearing and Vision Plan			0	10.00		
	Life Insurance (If employee is owner or beneficiary)			30, 411			
	Accident Insurance (If employee is owner or beneficiary)			0	12. 00		
13. 00	Disability Insurance (If employee is owner or beneficiary)			64, 034			
	Long-Term Care Insurance (If employee is owner or beneficiary)			0	1		
15. 00				102, 586	1		
16. 00	Retirement Health Care Cost (Only current year, not the extraordi	nary accrual required by	y FASB 106.	0	16. 00		
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only			1, 443, 299	1		
18. 00	Medicare Taxes - Employers Portion Only			0			
	Unemployment Insurance			0			
20. 00	State or Federal Unemployment Taxes			0	20. 00		
04 00	OTHER		4 1 (04 (04	04 00		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reportional)	ted on lines I through	4 above. (see	34, 694	21. 00		
22. 00	instructions)) Day Care Cost and Allowances			0	22. 00		
	Tuition Reimbursement			37, 948	1		
	Total Wage Related cost (Sum of lines 1 -23)			6, 208, 400			
24.00	Part B - Other than Core Related Cost			0, 208, 400	24.00		
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		I	0	25. 00		
25.00	OTHER WAGE RELATED COSTS (SPECIFI)		Ţ	ام	25.00		

Heal th	Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW		In Lie	u of Form CMS-2	2552-10
HOSPI 7	AL CONTRACT LABOR AND BENEFIT COST		Provi der CCN:		Peri od:	Worksheet S-3	
					From 01/01/2014		
					Го 12/31/2014	Date/Time Prep 5/29/2015 7:34	oared: 4 am
	Cost Center Description				Contract Labor	Benefit Cost	
					1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Ident	ti fi cati on:					
1.00	Total facility's contract labor and benefi	t cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovi der - I PF						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
	1						

8.00

9.00 10.00 11.00

0 12.00

13.00 14. 00 15.00 16.00 17.00 0 18.00

Hospi tal -Based SNF

12.00 Separately Certified ASC

12.00 | Separately Certified ASC 13.00 | Hospital - Based Hospice 14.00 | Hospital - Based Health Clinic RHC 15.00 | Hospital - Based Health Clinic FQHC 16.00 | Hospital - Based - CMHC 17.00 | Renal Dialysis 18.00 | Other

9. 00 Hospi tal -Based NF 10. 00 Hospi tal -Based NF 11. 00 Hospi tal -Based HHA

8.00

Heal th	Financial Systems ORTHOPAEDIC HOSPT. AT	PARKVI EW		In Lie	eu of Form CMS-2	2552-10		
			CCN: 150167	Peri od:	Worksheet S-10			
				From 01/01/2014	5 . (7)			
				To 12/31/2014	Date/Time Prep 5/29/2015 7:3			
					1. 00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)	ded by lin	ne 202 column	1 8)	0. 195603	1. 00		
2. 00	Net revenue from Medicaid				820, 692	2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				γ	3. 00		
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental p	navments i	from Medicaio	1?	Ň	4. 00		
5. 00	If line 4 is "no", then enter DSH or supplemental payments from N				613, 849	5. 00		
6. 00	Medicaid charges				12, 570, 098	6. 00		
7.00	Medicaid cost (line 1 times line 6)				2, 458, 749	7. 00		
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lir	nes 2 and 5; if	1, 024, 208	8. 00		
	< zero then enter zero)							
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for ea	ach line)					
9.00	Net revenue from stand-alone SCHIP				0	9. 00		
10. 00	Stand-al one SCHIP charges				0	10. 00		
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0			
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	inus line 9;	if < zero then	0	12. 00		
	enter zero)	estions fo	ar acab lina					
13. 00	Other state or local government indigent care program (see instru Net revenue from state or local indigent care program (Not include				353, 416	12 00		
14. 00	Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients covered under state or local indigent care program (Not include Charges for patients).				2, 237, 173			
14.00	10)	n ogralli (i	Not Theraueu	TH TIMES 0 01	2, 237, 173	14.00		
15. 00	State or local indigent care program cost (line 1 times line 14)				437, 598	15. 00		
16. 00	Difference between net revenue and costs for state or local indice	ent care	program (lin	ne 15 minus line	84, 182			
	13; if < zero then enter zero)	,						
	Uncompensated care (see instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to fund					17. 00		
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	1, 108, 390	19. 00		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
	I=		1.00	2. 00	3. 00			
20. 00	Total initial obligation of patients approved for charity care (a		1, 89	645, 494	647, 387	20. 00		
21. 00	charges excluding non-reimbursable cost centers) for the entire f Cost of initial obligation of patients approved for charity care		37	70 126, 261	126, 631	21. 00		
21.00	times line 20)	(IIIIe I	3.	120, 201	120, 031	21.00		
22. 00	Partial payment by patients approved for charity care			0 8, 454	8, 454	22. 00		
23. 00	, , , , , , , , , , , , , , , , , , , ,		37		118, 177			
	1			,,				
24.00	De the amount in line 20 relume 2 include shows for notice to	l		.e 1	1. 00	24.00		
24. 00	Does the amount in line 20 column 2 include charges for patient cimposed on patients covered by Medicaid or other indigent care pr		nd a rength d	or Stay IImit	N	24. 00		
25. 00			naram's Lenat	h of stav limit	0	25. 00		
26. 00								
27. 00	Medicare bad debts for the entire hospital complex (see instructi				29, 123			
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	,	s line 27)		1, 776, 027			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (The		,	28)	347, 396			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			-/	465, 573			
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			1, 573, 963			
	, , , , , , , , , , , , , , , , , , , ,	,						

Heal th	Financial Systems	ORTHOPAEDIC HOSPT	. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN: 150167 P	eri od:	Worksheet A	
				F	rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/29/2015 7:3	pared: 4 am
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)		
						(col. 3 +-	
						col . 4)	
	OFNEDAL CEDIM OF COCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		2 200 042	2 200 042	1 152 402	1 22/ //0	1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 380, 043				
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	0	1, 025, 172		2.00
3.00	00300 OTHER CAP REL COSTS	1 404 (17	2 522 070	4 000 505	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 494, 617	2, 533, 978		0	4, 028, 595	4.00
5. 00 6. 00	1 1	627, 008	12, 417, 232	13, 044, 240	_	13, 044, 240	5.00
	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT	127, 069	E10 070	637, 139	651 -382	651	6. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	127,009	510, 070	037, 139	-362	636, 757 0	8.00
9. 00	00900 HOUSEKEEPING		457, 288	457, 288	0	457, 288	9. 00
10.00	01000 DI ETARY		203, 091		0	203, 091	
11. 00	01100 CAFETERI A		203, 091	203, 091	0	203, 041	
12. 00	01200 MAINTENANCE OF PERSONNEL		0	0	0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION		0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		27, 027	27, 027	0	27, 027	14. 00
15. 00	01500 PHARMACY		24, 130		0	24, 130	
16. 00	01600 MEDICAL RECORDS & LIBRARY		21, 100	21,100	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	143, 910	25, 864	169, 774	0	169, 774	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	o	0	0	0	0	20. 00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRV	o	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	0	0	0	0	22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 667, 310	276, 652	1, 943, 962	-26, 177	1, 917, 785	30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	3, 170, 410	21, 519, 488				
53. 00	05300 ANESTHESI OLOGY	0	1, 937				
54.00	05400 RADI OLOGY-DI AGNOSTI C	244, 987	430, 689		0	675, 676	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	20/ 250	_	0	0	58. 00
60.00	06000 LABORATORY	0	396, 359		0	396, 359	
62. 00 62. 30	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	33, 494 0		0	33, 494 0	62. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY		74, 786	1	0	74, 786	
66. 00	06600 PHYSI CAL THERAPY	565, 022	9, 217		0	574, 239	
69. 00	06900 ELECTROCARDI OLOGY	000,022	950		0	950	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	i e	2, 393, 748	l	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0		15, 547, 855		
73. 00	07300 DRUGS CHARGED TO PATIENTS	61, 886	1, 408, 548	1	0	1, 470, 434	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	132	132	0	132	
76. 99	07699 LI THOTRI PSY	o	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	1, 073	1, 073	0	1, 073	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
	11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 731, 332	8, 782, 554				
118.00		11, 833, 551	51, 514, 602	63, 348, 153	0	63, 348, 153	118. 00
404.00	NONREI MBURSABLE COST CENTERS	10 (33)	/4 0/0	400.010		400.040	104.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	42, 677	61, 263		0	103, 940 63, 452, 093	
200.00	TOTAL (SUM OF LINES 118-199)	11, 876, 228	51, 575, 865	63, 452, 093	1	05, 452, 093	200.00

Peri od: From 01/01/2014 To 12/31/2014

Worksheet A Date/Time Prepared: 5/29/2015 7:34 am

				5/29/2015 7:3	34 am
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	_			
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	., ===,		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0		1	2. 00
3.00	00300 OTHER CAP REL COSTS	0	1	l .	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-112, 642			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 648, 756			5. 00
6.00	00600 MAINTENANCE & REPAIRS	0			6. 00
7.00	00700 OPERATION OF PLANT	0			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0	,		9. 00
10.00	01000 DI ETARY	0	203, 091		10.00
11. 00	01100 CAFETERI A	0	0		11. 00
12.00	1	0			12.00
13.00		0	0		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	27, 027		14. 00
15.00	01500 PHARMACY	0	24, 130		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
17.00	01700 SOCIAL SERVICE	0	169, 774		17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000 NURSI NG SCHOOL	0	0		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	O		21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00		0	1, 917, 785		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	5, 609, 466		50.00
53.00	05300 ANESTHESI OLOGY	0	1, 166, 674		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	675, 676		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
60.00		0	396, 359		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	33, 494		62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65.00		0	74, 786		65. 00
66. 00		0			66.00
69. 00	06900 ELECTROCARDI OLOGY	0			69.00
71. 00		0			71. 00
72. 00		0		1	72. 00
73. 00	1	0		1	73. 00
76. 97	1	0	.,,	l .	76. 97
76. 98	1 1	0		l .	76. 98
76. 99		0		•	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS				1 70. 77
90. 00		0	1, 073		90.00
92. 00			1,070		92. 00
72.00	SPECIAL PURPOSE COST CENTERS				72.00
115 0	11500 AMBULATORY SURGICAL CENTER (D. P.)	Ιο	12, 642, 117		115. 00
118. 00		1, 536, 114		•	118. 00
	NONREI MBURSABLE COST CENTERS	1, 550, 114	01,004,207		1
194 ∩	07950 OTHER NONREIMBURSABLE COST CENTERS	T 0	103, 940		194. 00
200.00		1, 536, 114		•	200.00
200.00	1.017.2 (00.01 21 110 177)	1, 550, 114	1 51,700,207	I .	1200.00

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150167

						29/2015 7:34 am
		Increases			1 07.	
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - BUILDING DEPRECIATON					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 025, 172		1. 00
2.00	AMBULATORY SURGICAL CENTER	115. 00	0	128, 231		2. 00
	(D. P.)	↓				
	0		0	1, 153, 403		
	B - MED AND IV SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	17, 941, 603		1.00
	PATI ENT		_			
2.00		0.00		0		2. 00
	0		0	17, 941, 603		
4 00	C - TELEPHONE EXPENSE	(00		/54		
1.00	MAINTENANCE & REPAIRS	6.00	0	651		1.00
2.00		0.00	•	0		2.00
	D DENEELTS ALLOCATION		0	651		
1 00	D - BENEFITS ALLOCATION	4 00	ما	1 404 (17		1.0
1.00	EMPLOYEE BENEFITS DEPARTMENT			1, 494, 617		1. 00
	TOTALS		0	1, 494, 617		
1 00	F - HOME OFFICE	F 00	4 407 100			1.0
1. 00	ADMI NI STRATI VE & GENERAL		4, 407, 103	0		1.00
	U DUDCHASED SERVICES		4, 407, 103	U		
1 00	H - PURCHASED SERVICES ADMINISTRATIVE & GENERAL	5. 00	694, 914	0		1.0
1. 00 2. 00	OPERATION OF PLANT	7. 00	272, 571	0		1.00
3. 00	HOUSEKEEPI NG	9. 00	294, 197	0		3.00
4. 00	DI ETARY	10.00	203, 091	0		4.00
				0		
5. 00 6. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	27, 027 24, 130	0		5. 00
7.00	ADULTS & PEDIATRICS	30.00	28, 610	0		7.00
8.00	OPERATING ROOM	50.00	882, 759	0		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	358, 672	0		9.00
10.00	LABORATORY	60.00	396, 359	0		10.00
11. 00	RESPIRATORY THERAPY	65.00	74, 786	0		11.00
12. 00	PHYSI CAL THERAPY	66.00	144	0		12. 00
13. 00	DRUGS CHARGED TO PATIENTS	73.00	503, 145	0		13.00
14. 00	CLI NI C	90.00	1, 073	0		14. 00
15. 00	AMBULATORY SURGICAL CENTER	115.00	24, 386	0		15. 00
13.00	(D. P.)	113.00	24, 300	J		15.00
16. 00	OTHER NONREI MBURSABLE COST	194.00	141	0		16. 00
10.00	CENTERS	174.00	171			10.00
		+	3, 786, 005	₀		
	I - IMPLANTS		2, . 22, 200	=		
1.00	IMPL. DEV. CHARGED TO	72.00	0	15, 547, 855		1. 00
	PATI ENTS		7	, ,		
				15, 547, 855		
	J - ANESTHESIA	·				
1.00	ANESTHESI OLOGY	53.00	0	1, 164, 737		1. 00
		+		1, 164, 737		
	K - ASC BENEFITS	<u>'</u>	.,			
1.00	AMBULATORY SURGICAL CENTER	115. 00	0	81, 307		1. 0
	(D. P.)					
				81, 307		
500 00	Grand Total: Increases		8, 193, 108	37, 384, 173		500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150167

					To	12/31/2014	Date/Time Prepared: 5/29/2015 7:34 am
		Decreases		•			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - BUILDING DEPRECIATON						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 153, 403			1. 00
2.00		0.00	0	0			2. 00
	0		0	1, 153, 403			
	B - MED AND IV SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	26, 177	1		1.00
2.00	OPERATING ROOM	5000	0	<u>17, 915, 426</u>			2. 00
	0		0	17, 941, 603			
	C - TELEPHONE EXPENSE	- aal	al				
1.00	OPERATION OF PLANT	7. 00	0	382			1.00
2.00	OPERATING ROOM	5000	•				2. 00
	U PENEELTS ALLOCATION		U	651			
1 00	D - BENEFITS ALLOCATION	4 00	1 404 (17				1.00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 494, 617	0			1.00
	TOTALS F - HOME OFFICE		1, 494, 617	0	1		
1 00		F 00	0	4 407 102	O		1.00
1.00	ADMI NI STRATI VE & GENERAL			4, 407, 103 4, 407, 103			1.00
	H - PURCHASED SERVICES		U	4, 407, 103	1		
1.00	ADMINISTRATIVE & GENERAL	5. 00		694, 914	. 0		1, 00
2.00	OPERATION OF PLANT	7. 00	0	272, 571	l l		2.00
3.00	HOUSEKEEPI NG	9.00	0	294, 197	l l		3.00
4.00	DI ETARY	10.00	0	203, 091	- 1		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	27, 027	l l		5. 00
6. 00	PHARMACY	15. 00	0	24, 130			6. 00
7. 00	ADULTS & PEDIATRICS	30.00	0	28, 610	l l		7. 00
8. 00	OPERATING ROOM	50.00	0	882, 759			8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	358, 672			9.00
10. 00	LABORATORY	60.00	0	396, 359	1		10.00
11. 00	RESPIRATORY THERAPY	65. 00	0	74, 786			11. 00
12. 00	PHYSI CAL THERAPY	66. 00	0	144			12.00
13. 00	DRUGS CHARGED TO PATIENTS	73. 00		503, 145	1		13.00
14. 00	CLINIC	90.00	0	1, 073	1		14. 00
15. 00	AMBULATORY SURGICAL CENTER	115. 00	0	24, 386			15.00
13.00	(D. P.)	113.00	ď	24, 300			15.00
16. 00	OTHER NONREI MBURSABLE COST	194. 00	0	141	0		16. 00
10.00	CENTERS	171.00	Ĭ				10.00
	0	+		3, 786, 005			
	I - IMPLANTS			0,700,000			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	15, 547, 855	0		1.00
	PATI ENT		1	, ,			
				15, 547, 855			
	J - ANESTHESI A		7				
1.00	OPERATING ROOM	50.00	0	1, 164, 737	0		1.00
		— — — ' †		1, 164, 737			
	K - ASC BENEFITS	<u>'</u>			·		
1.00	AMBULATORY SURGICAL CENTER	115.00	81, 307	0	0		1. 00
	(D. P.)	`	`				
	0		81, 307				
500.00	Grand Total: Decreases		1, 575, 924	44, 001, 357			500.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150167 Peri od: Worksheet A-7 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 2.00 Land Improvements 0 0 2.00 6, 000 0 3.00 9, 446, 043 6,000 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 1,505,293 1, 826, 608 1, 826, 608 0 4.00 5.00 Fixed Equipment 8, 786, 262 0 0 5.00 0 6.00 Movable Equipment 8, 434, 573 1, 298, 270 1, 298, 270 0 6.00 0 7.00 374, 743 HIT designated Assets 2, 366, 145 374, 743 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 30, 538, 316 3, 505, 621 3, 505, 621 0 8.00 9.00 Reconciling Items -377, 667 195, 217 0 195, 217 0 9.00 30, 915, 983 Total (line 8 minus line 9) 3, 310, 404 10.00 10.00 3, 310, 404 0 0 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 2.00 Land Improvements 2.00 3.00 Buildings and Fixtures 9, 452, 043 3.00 4.00 Building Improvements 3, 331, 901 119, 037 4.00 5.00 Fi xed Equipment 8, 786, 262 5.00 Movable Equipment 9, 732, 843 6.00 2, 287, 914 6.00 7.00 HIT designated Assets 2, 740, 888 7.00 Subtotal (sum of lines 1-7) 8.00 34, 043, 937 2, 406, 951 8.00 9.00 Reconciling Items -182, 450 9.00

34, 226, 387

2, 406, 951

10.00 Total (line 8 minus line 9)

Hoal th	Financial Systems (ORTHOPAEDIC HOSE	OT AT DADKVIEW		In Lieu of Form CMS-2552-10			
	CILIATION OF CAPITAL COSTS CENTERS	ACTION ALDI C 11031		CCN: 150167	Peri od:	Worksheet A-7	2332-10	
KLCOW	CILIATION OF CAPITAL COSTS CLINERS		FIOVIDE	CCN. 150107	From 01/01/2014			
						Date/Time Pre	pared:	
						5/29/2015 7: 3		
			Sl	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)	instructions)		
		9.00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	2, 380, 043	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, 380, 043	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	n				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 380, 043				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			l	2. 00	
	1 - 1 (1		.1				

0 0 0

2, 380, 043

1. 00 2. 00 3. 00

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

Heal th	Financial Systems C	RTHOPAEDIC HOSI	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Preps/29/2015 7:34	pared:	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance		
	DADT III DECONCLITATION OF CADITAL COSTS OF	1.00	2. 00	3. 00	4. 00	5. 00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	21, 570, 207	1	21, 570, 20	0. 704731	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	9, 732, 842	l .				2. 00	
3.00	Total (sum of lines 1-2)	31, 303, 049					3. 00	
			ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum o cols. 5 through 7)	f Depreciation	Lease		
		6.00	7.00	8. 00	9. 00	10. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 226, 640		1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 025, 172		2.00	
3.00	Total (sum of lines 1-2)	0	0	<u> </u> JMMARY OF CAPI	0 2, 251, 812	0	3. 00	
			30	JIVIIVIART OF CAPI	TAL			
	Cost Center Description	Interest	Insurance (see instructions)	,	Other) Capi tal -Rel ate d Costs (see i nstructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13. 00	14.00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		1					
1.00	CAP REL COSTS-BLDG & FLXT	0		•	0	1, 226, 640	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	_		0	1, 025, 172	2.00	
3.00	Total (sum of lines 1-2)	0	0	1	0 0	2, 251, 812	3. 00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-2552-10 Provider CCN: 150167 Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-8 Date/Time Prepared: 5/29/2015 7:34 am Expense Classification on Worksheet A

		To/From Which the Amount is	ch the Amount is to be Adjusted				
	Coot Contan Decement on	Dani a (Cada (2)	Amount	Coot Conton	Line #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	4. 00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
0.00	COSTS-MVBLE EQUIP (chapter 2)						0.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	o	6. 00
0.00	suppliers (chapter 8)		O		0.00		0.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	О	9. 00
10. 00	Provider-based physician adjustment	A-8-2	0			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 650, 356			0	12. 00
	transactions (chapter 10)	7.01					
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0		0.00		15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
40.00	patients						40.00
18. 00	Sale of medical records and abstracts		U		0. 00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	О	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments	<u>'</u>					
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	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	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
20.00	limitation (chapter 14)		-	ADULTO A DEDLATELOS	20.22		20.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest OTHER OPERATING REVENUE	В	-451	ADMINISTRATIVE & GENERAL	5. 00	О	33. 00
34. 00	OTHER OPERATING REVENUE	В	-1, 149	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00

Health Financial Systems			OI	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lieu of Form CMS-2552-10			
	ADJUST	MENTS TO EXPENSES			Provi der CC		eri od:	Worksheet A-8		
							rom 01/01/2014			
							o 12/31/2014	Date/Time Pre 5/29/2015 7:3		
					Expense Classi	fication on	Worksheet A	3/2//2013 7.3	- aiii	
					To/From Which the					
		Cost Center Description	Basis/Code (2)	Amount	Cost Cen	iter	Li ne #	Wkst. A-7 Ref.		
			1.00	2. 00	3.00		4. 00	5. 00		
	35.00	SELF INSURANCE OFFSET	A	-112, 642	EMPLOYEE BENEFITS	S DEPARTMENT	4.00	C	35. 00	
	50.00	TOTAL (sum of lines 1 thru 49)		1, 536, 114					50.00	
		(Transfer to Worksheet A,								
		column 6 line 200)	[

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

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

 B. Amount Received if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

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

 a not seen poeted to not hence till octamine i diserci 2, the dimenti direndere chedia se indicated in octamin i or time parti									
			Related Organization(s) and/	or Home Office					
			incrated organization(3) and	or mome orrice					
		_		I	-				
Symbol (1)	Name	Percentage of	Name	Percentage of					
, ,									
		Ownershi p		Ownershi p					
1. 00	2. 00	3, 00	4, 00	5. 00					
1. 00	2.00	3.00	4. 00	5.00					
R INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE.							
D. THILKKELATIONSHIT TO KELAT	LD ONGAINT LATTION (3) AND FOR THE	WL OITTOL.							

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

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

6.00	В	O.OO PARKVIEW HEALTH SYSTEM, INC	60.00	6. 00
7.00	В	0. 00 NORTHEAST_ORTHOPAEDIC	40.00	7. 00
		HOSPI TAL I NVE		
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:

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

line 12.

- 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.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems		ORTH0	PAEDI C	HOSPT. AT	PARKVI EW			In Lie	u of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI O	NS AND	HOME	Provi der	CCN:	150167	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS									From 01/01/2014	D-+- /T: D	
										To 12/31/2014	Date/Time Pro	
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS I NCURI	RED AND ADJUST	MENTS RE	QUIRED AS A	RESULT	OF TRANS	ACTIONS W	/ITH F	RELATED (ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COS	STS:										
1.00	1, 650, 356	(1.00
2.00	0	(2. 00
3.00	0	(3.00
4.00	0	(4.00
5.00	1, 650, 356											5.00
* The	* 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

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	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 reimbursement under title XVIII.

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.
- 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 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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150167 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1, 226, 640 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 226, 640 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 025, 172 1, 025, 172 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 915, 953 3, 915, 953 4.00 00500 ADMINISTRATIVE & GENERAL 14, 692, 996 297, 792 5 00 18, 124 1, 213, 107 16, 222, 019 5 00 6.00 00600 MAINTENANCE & REPAIRS 651 C 651 6.00 7.00 00700 OPERATION OF PLANT 636, 757 358 84.623 721, 738 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 C 0 00900 HOUSEKEEPI NG 457, 288 62, 296 9 00 1 026 520, 610 Ω 9 00 10.00 01000 DI ETARY 203, 091 5, 699 43,004 251, 794 10.00 01100 CAFETERI A 11.00 0 0 0 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 0 0 01300 NURSING ADMINISTRATION 13.00 0 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 27,027 0 5, 723 32, 750 14.00 01500 PHARMACY 15.00 24, 130 5, 110 29, 240 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16, 00 16.00 0 0 17 00 01700 SOCIAL SERVICE 169, 774 0 30.473 200, 247 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 20.00 02000 NURSING SCHOOL 0 Ω 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1. 917. 785 333, 445 136, 281 359, 109 2, 746, 620 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 5, 609, 466 7, 579, 310 50.00 554, 221 557, 369 858, 254 50.00 53.00 05300 ANESTHESI OLOGY 1, 166, 674 1, 166, 674 53.00 C54.00 05400 RADI OLOGY-DI AGNOSTI C 675, 676 23, 281 0 127, 824 826, 781 54.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 304,660 58.00 304,660 58.00 60.00 06000 LABORATORY 396, 359 Ω 0 83, 929 480, 288 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 33, 494 62.00 33, 494 C 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 06500 RESPIRATORY THERAPY 65.00 74, 786 C 15, 836 90, 622 65.00 06600 PHYSI CAL THERAPY 17, 901 119, 673 713, 468 66.00 574, 239 1,655 66.00 06900 ELECTROCARDI OLOGY 950 950 69.00 C 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 393, 748 C 0 0 2, 393, 748 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 547, 855 0 15, 547, 855 72.00 07300 DRUGS CHARGED TO PATIENTS 0 119, 645 1, 590, 079 73 00 1, 470, 434 Ω 73 00 07697 CARDIAC REHABILITATION 76.97 C 0 n 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 132 0 132 76. 98 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1,073 0 0 227 1, 300 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)
118.00 SUBTOTALS (SUM OF LINES 1-117) 12, 642, 117 0 778 053 13, 420, 170 115, 00 64, 884, 267 1, 226, 640 1, 025, 172 3, 906, 886 64, 875, 200 118. 00 NONREIMBURSABLE COST CENTERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 113, 007 194. 00 103.940 9.067 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 64, 988, 207 1, 025, 172 3, 915, 953 202.00 TOTAL (sum lines 118-201) 1, 226, 640 64, 988, 207 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150167

				''	0 12/31/2014	5/29/2015 7:3	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	•					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 222, 019					5. 00
6.00	00600 MAINTENANCE & REPAIRS	217	868				6. 00
7.00	00700 OPERATION OF PLANT	240, 085	0	961, 823			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0		8. 00
9.00	00900 HOUSEKEEPI NG	173, 180	0	0	0	693, 790	9. 00
10.00	01000 DI ETARY	83, 759	0	0	0	0	10. 00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	10, 894	0	0	0	0	14. 00
15.00	01500 PHARMACY	9, 727	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	. 0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	66, 612	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 &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-(SPECIFY)	0	0	Ö	0	0	23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					-	
30.00	03000 ADULTS & PEDIATRICS	913, 660	312	345, 282	0	249, 062	30.00
	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATING ROOM	2, 521, 250	517	573, 897	0	413, 968	50.00
53.00	05300 ANESTHESI OLOGY	388, 093	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	275, 028	22	24, 107	0	17, 389	54.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	101, 345				0	58. 00
60.00	06000 LABORATORY	159, 767	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11, 142	0	0	0	0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	30, 145	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	237, 334	17	18, 537	0	13, 371	66. 00
69.00	06900 ELECTROCARDI OLOGY	316	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	796, 278	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 171, 975	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	528, 938	0	0	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	44	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS		<u>'</u>				
90.00	09000 CLI NI C	432	0	0	0	0	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS	•					1
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	4, 464, 206	0	0	0	0	115. 00
118.00	1 1	16, 184, 427	868	961, 823	0	693, 790	118. 00
	NONREI MBURSABLE COST CENTERS						1
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	37, 592	0	0	0	0	194. 00
200.00							200. 00
201.00		0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	16, 222, 019	868	961, 823	0	693, 790	202. 00
		•		•	,	•	•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

			'	0 12/31/2014	5/29/2015 7:3	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
, , , , , , , , , , , , , , , , , , ,			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
GENERAL SERVI CE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6.00
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	335, 553					10.00
11. 00 01100 CAFETERI A	0	0				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	1			12. 00
13.00 01300 NURSING ADMINISTRATION	O	0		ol		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	0	1 0	ol	43, 644	14. 00
15. 00 01500 PHARMACY	0	0		o	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	0		o	0	16. 00
17. 00 01700 SOCIAL SERVICE	O	0		o	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	O	0		o	0	19. 00
20. 00 02000 NURSI NG SCHOOL	O	0		o	0	20. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	O	0		o	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0			0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-1	-				
30. 00 03000 ADULTS & PEDI ATRI CS	335, 553	0		0	0	30. 00
ANCI LLARY SERVI CE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		o	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		o	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		o	0	58. 00
60. 00 06000 LABORATORY	o	0	1	ol	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		o	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0		o	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	O	0		o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	O	0		o	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0		o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0		o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0		o	43, 644	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0		o	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	O	0		o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	O	0		o	0	76. 98
76. 99 07699 LI THOTRI PSY	O	0		o	0	76. 99
OUTPATIENT SERVICE COST CENTERS	-1			-1		
90. 00 09000 CLI NI C	0	0	(0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS	ļ.			1		
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0	115. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	335, 553	0			43, 644	
NONREI MBURSABLE COST CENTERS	,			<u> </u>	,	
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0	194. 00
200.00 Cross Foot Adjustments	٩	· ·]		ŭ	200. 00
201.00 Negative Cost Centers	o	0		ol ol	0	201. 00
202.00 TOTAL (sum lines 118-201)	335, 553	0	d	o	43, 644	
. , ,			•			

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 24/31/2014 | Part | P

					0 12/31/2014	Date/lime Pre 5/29/2015 7:3	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	T GIII
	, , , , , , , , , , , , , , , , , , ,		RECORDS &		ANESTHETI STS		
			LI BRARY				
	Ta	15. 00	16. 00	17. 00	19. 00	20.00	
4 00	GENERAL SERVICE COST CENTERS					I	4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
2. 00 4. 00							
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	00600 MAINTENANCE & REPAIRS						5. 00 6. 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
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY	38, 967					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	o	(o			16.00
17. 00	01700 SOCIAL SERVICE	0	(266, 859			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	(o	0		19. 00
20.00	02000 NURSI NG SCHOOL	0	(0	0	0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	() C	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	(1	-	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	() C	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	ام		al a ass		1	
30. 00	03000 ADULTS & PEDIATRICS	0	(266, 859) C	0	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	(C	0	50.00
53. 00	05300 ANESTHESI OLOGY	0	(1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		(-	Ö	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o o	(_	ő	58.00
60. 00	06000 LABORATORY	0	(1		o o	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	(Ō	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	() c	0	
65.00	06500 RESPI RATORY THERAPY	o	(ol d) c	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	(0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	o	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(o	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0) C	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	38, 967	(1	_	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	(0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	(-	0	
76. 99	07699 LI THOTRI PSY	0	() C	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	() C	0	90.00
90.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	۷	(0	90.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(C	0	115. 00
118.00	, ,	38, 967	(118. 00
2.00	NONREI MBURSABLE COST CENTERS						1
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	() C	0	194. 00
200.00	Cross Foot Adjustments				C	0	200. 00
201.00		0	(o	C		201. 00
202.00	TOTAL (sum lines 118-201)	38, 967	(266, 859	p c	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150167 Peri od: Worksheet B From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Intern & Y & FRINGES PRGM COSTS Residents Cost PRGM APPRV **APPRV** & Post Stepdown Adjustments 21. 00 22.00 23.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 C 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 4, 857, 348 30.00 O ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 11, 088, 942 50.00 0 0 50.00 0 53.00 05300 ANESTHESI OLOGY 0 0 1, 554, 767 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 1, 143, 327 0 54.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 000000000000 406, 005 58.00 58.00 0 0 60.00 06000 LABORATORY 0 640, 055 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 44,636 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 120, 767 0 06600 PHYSI CAL THERAPY 0 982, 727 66.00 66.00 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 1, 266 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 3, 190, 026 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 20, 763, 474 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2. 157. 984 73.00 73 00 0 07697 CARDIAC REHABILITATION 0 76.97 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 176 0 76. 98 07699 LI THOTRI PSY 76. 99 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 1, 732 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 Ω 0 17, 884, 376 0 115 00 0 0 0 64, 837, 608 0 118.00 NONREIMBURSABLE COST CENTERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194. 00 0 150, 599 0 Cross Foot Adjustments 0 0 200. 00 200.00 0 0 0 201.00 Negative Cost Centers 0 0 201. 00

64, 988, 207

0 202. 00

202.00

TOTAL (sum lines 118-201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150167

			5/29/2015 7:3	
	Cost Center Description	Total		
		26.00		
	GENERAL SERVI CE 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
6.00	00600 MAINTENANCE & REPAIRS			6. 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
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00	01700 SOCIAL SERVICE			17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS			19. 00
20.00	02000 NURSI NG SCHOOL			20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			23. 00
30. 00	03000 ADULTS & PEDIATRICS	4, 857, 348		30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	4,007,040		30.00
50.00	05000 OPERATING ROOM	11, 088, 942		50.00
53. 00	05300 ANESTHESI OLOGY	1, 554, 767		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 143, 327		54.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	406, 005		58. 00
60.00	06000 LABORATORY	640, 055		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 636		62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o		62. 30
65.00	06500 RESPI RATORY THERAPY	120, 767		65. 00
66.00	06600 PHYSI CAL THERAPY	982, 727		66. 00
69.00	06900 ELECTROCARDI OLOGY	1, 266		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 190, 026		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 763, 474		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 157, 984		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	176		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	1, 732		90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
445 00	SPECIAL PURPOSE COST CENTERS	47.004.07/		115 00
115. 00 118. 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	17, 884, 376		115.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	64, 837, 608		118. 00
10/ 00	07950 OTHER NONREIMBURSABLE COST CENTERS	150, 599		194. 00
200.00		150, 599		200. 00
200.00	1 1			200.00
201.00		64, 988, 207		201.00
_52.50	1:07.12 (04 17.100 110 201)	0., 700, 207		1=02.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150167 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 1, 638, 529 297, 792 18, 124 1, 954, 445 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 0 00700 OPERATION OF PLANT 7.00 0 C 358 358 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 8.00 00900 HOUSEKEEPI NG 0 0 0 1.026 9.00 9 00 1 026 0 01000 DI ETARY 10.00 0 5, 699 5,699 0 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 00000000 0 0 0 12.00 01300 NURSING ADMINISTRATION 0 13 00 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 14.00 01500 PHARMACY 0 0 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 01700 SOCIAL SERVICE 17.00 0 Ω 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22 00 C 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 333, 445 136, 281 469, 726 30.00 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 554, 221 557, 369 1, 111, 590 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 23, 281 54.00 23, 281 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 304,660 304,660 0 58.00 06000 LABORATORY 0 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 17, 901 1,655 19, 556 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 C 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 0 0 76. 97 Λ 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98

0 76.99

0

90.00

92.00

0 115 00

0 118.00

0 194. 00

0 201.00

0 202.00

200.00

76. 99

90.00

118.00

200 00

201.00

202.00

MCRI F32 - 7. 2. 157. 2

07699 LI THOTRI PSY

09000 CLI NI C

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)

09200 OBSERVATION BEDS (NON-DISTINCT PART

SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS

194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

0

0

1, 638, 529

1, 638, 529

0

1, 226, 640

1, 226, 640

0

0

1, 025, 172

1, 025, 172

0

0

3, 890, 341

3, 890, 341

0 194. 00

0 201.00

21, 891 202. 00

200.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150167 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 1, 954, 445 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 26 6.00 26 00700 OPERATION OF PLANT 29, 284 7.00 28, 926 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 C 00900 HOUSEKEEPI NG 0 0 21, 891 9.00 20.865 0 9 00 0 10.00 01000 DI ETARY 10, 091 0 10.00 0 11.00 01100 CAFETERI A 0 0 0 0 0 0 0 0 0 0 0 0 0 11.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 12 00 0 0 13.00 01300 NURSING ADMINISTRATION 0 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 313 0 0 14.00 01500 PHARMACY 0 15.00 0 15.00 1, 172 0 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 0 16.00 17.00 01700 SOCIAL SERVICE 8,025 0 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 0 0 02000 NURSING SCHOOL 0 0 20.00 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 0 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 110, 079 9 10, 513 0 7, 859 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 303, 764 15 0 13, 061 50.00 17.473 05300 ANESTHESI OLOGY 0 53.00 46, 758 C \cap Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 136 734 0 549 54.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 12, 210 58.00 C 0 0 0 0 58.00 06000 LABORATORY 19, 249 0 0 60.00 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 1, 342 0 0 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 06500 RESPIRATORY THERAPY 65.00 3,632 0 0 0 0 0 0 0 0 65.00 66 00 06600 PHYSI CAL THERAPY 28, 594 564 422 66 00 06900 ELECTROCARDI OLOGY 69.00 38 0 C 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 95, 937 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 623, 121 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 63,727 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 5 0 0 0 76.98 76 99 07699 LI THOTRI PSY 0 Ω O 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 52 0 0 0 0 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 537, 854 0 0 0 115, 00 SUBTOTALS (SUM OF LINES 1-117) 1, 949, 916 26 29, 284 21, 891 118. 00

4.529

1, 954, 445

Ω

26

0

29. 284

0

0

0

118.00

200.00

201.00

202.00

NONREI MBURSABLE COST CENTERS

194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | Taken | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150167

					lo 12/31/2014	Date/lime Pre 5/29/2015 7:3	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	4 alli
	cost center bescription	DILIAKI	CALLILITA	PERSONNEL	ADMI NI STRATI ON		
				TERSONNEL	ADMINI STRATTON	SUPPLY	
		10.00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 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	15, 790					10.00
11. 00	01100 CAFETERI A	10,770	(11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL		(1			12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON		C	1	o o		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		(1	0	1, 313	14. 00
15. 00	01500 PHARMACY		(1			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		(1		_	16. 00
17. 00	01700 SOCIAL SERVICE		(1	0	-	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS					_	19.00
20. 00	02000 NURSI NG SCHOOL			1		0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	(1		0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	(1			22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	(1			23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U U		ή '	<u>J</u>	U	23.00
30. 00	03000 ADULTS & PEDIATRICS	15, 790	C		0 0	0	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	13, 770		<u>' </u>	<u> </u>	0	30.00
50. 00	05000 OPERATING ROOM	O	C		0	0	50.00
53. 00	05300 ANESTHESI OLOGY		C	1	o o		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		(0		54.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		(1	0	0	58. 00
60. 00	06000 LABORATORY		(1		-	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		(62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		(1		0	62. 30
65. 00	06500 RESPIRATORY THERAPY		(0	65. 00
66. 00	06600 PHYSI CAL THERAPY		(1		0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(1		0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0	_	71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		(1		1, 313	
73. 00	07300 DRUGS CHARGED TO PATIENTS		(1		1, 313	73.00
76. 97	07697 CARDI AC REHABILITATION		(1	0	-	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		(1		_	76. 98
76. 99	07699 LI THOTRI PSY		(1			76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		' '	<u> </u>	0	70.77
90. 00	09000 CLINIC	0	C		0 0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			Ί			92.00
72.00	SPECIAL PURPOSE COST CENTERS			1			72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0 0	n	115. 00
118.00	1 ,	15, 790	(118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	13,770		'I '	<u> </u>	1,313	1 . 0. 00
194. 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	C		0	n	194. 00
200.00	l l			1			200. 00
201.00	,	0	C		0	n	201. 00
202.00		15, 790	C		o o		202. 00
	1 (.57.70		1	٠,	., 510	,

0 200. 00

0 201.00

0 202.00

0

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150167 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/29/2015 7:34 am Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL **ANESTHETI STS** RECORDS & LI BRARY 15. 00 17.00 19. 00 20.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 1, 172 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 0 8,025 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 C 02000 NURSING SCHOOL 0 Λ 20.00 20 00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 0 8, 025 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 n 50 00 05300 ANESTHESI OLOGY 00000000 0 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 06000 LABORATORY 0 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 06500 RESPIRATORY THERAPY 65 00 Ω 0 65 00 0 06600 PHYSI CAL THERAPY 0 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 Ω 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 172 0 0 73.00 76. 97 76. 97 07697 CARDIAC REHABILITATION 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 0 76.99 0 Ω OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 172 0 8,025 0 0 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 n O 194 00

1.172

0

0

8.025

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

ALLOCA	ATION OF CAPITAL RELATED COSTS			CCN: 150167	Peri od: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/29/2015 7:3	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	'	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
		APPRV	APPRV			& Post	
						Stepdown	
	+	21. 00	22. 00	23. 00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	21.00	22.00	25.00	24.00	23.00	
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
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00							10. 00
11. 00	1 1						11. 00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00							13.00
14. 00	1 1						14. 00
15.00	1 1						15. 00
16. 00 17. 00	1 1						16. 00 17. 00
17.00	1 1						17.00
20. 00	1 1						20. 00
21. 00		О					21. 00
22. 00	1 1		0				22. 00
23. 00					0		23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					_	
30. 00					622, 001	0	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM				1, 445, 903	0	50. 00
53. 00	1				46, 758	Ö	53. 00
54. 00	1 1				57, 701	0	54. 00
58. 00					316, 870	0	58. 00
60.00	06000 LABORATORY				19, 249	0	60.00
62. 00	1 1				1, 342	0	62.00
62. 30	1 1				0	0	62. 30
65. 00					3, 632	0	65. 00
66. 00 69. 00	1 1				49, 137 38	0	66. 00 69. 00
71. 00	1 1				95, 937	0	71. 00
72. 00	1 1				624, 434	Ö	72.00
73. 00					64, 899	Ō	73. 00
76. 97					0	0	76. 97
76. 98					5	0	76. 98
76. 99					0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS			Ι		0	00.00
	09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART				52		90. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS					U	92.00
115.00	0 11500 AMBULATORY SURGICAL CENTER (D. P.)				537, 854	0	115. 00
118.00		0	0		0 3, 885, 812	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 07950 OTHER NONREIMBURSABLE COST CENTERS				4, 529		194. 00
200.00	, ,	0	0		0 0		200.00
201. 00 202. 00		0	0		0 3, 890, 341		201. 00 202. 00
202.00		Ч	0	I	J, 070, 341	ا	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150167

			5/29/20)15 7:34 am
	Cost Center Description	Total		
	·	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 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6. 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
12.00	01200 MAINTENANCE OF PERSONNEL			12. 00
13.00	01300 NURSING ADMINISTRATION			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
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDIATRICS	622, 001		30, 00
00.00	ANCILLARY SERVICE COST CENTERS	0227001		
50. 00		1, 445, 903		50.00
53. 00	05300 ANESTHESI OLOGY	46, 758		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	57, 701		54.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	316, 870		58. 00
60. 00	06000 LABORATORY	19, 249		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 342		62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	06500 RESPIRATORY THERAPY	3, 632		65.00
66. 00	06600 PHYSI CAL THERAPY	49, 137		66. 00
69. 00	06900 ELECTROCARDI OLOGY	38		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95, 937		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	624, 434		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	64, 899		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	01,077		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5		76. 98
76. 79	07699 LI THOTRI PSY	o o		76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>		70.77
90. 00	09000 CLINIC	52		90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	52		92.00
72.00	SPECIAL PURPOSE COST CENTERS			72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	537, 854		115. 00
118.00		3, 885, 812		118. 00
110.00	NONREI MBURSABLE COST CENTERS	3,000,012		110.00
104 00	07950 OTHER NONREIMBURSABLE COST CENTERS	4, 529		194. 00
200.00	1	4, 529		200. 00
	1 1			200.00
201.00		2 900 241		
202.00	TOTAL (sum lines 118-201)	3, 890, 341		202. 00

Heal th	Financial Systems 0	RTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet B-1 Date/Time Pre	
					12,01,2011	5/29/2015 7: 3	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost conten bosci i pti cii		(DOLLAR VALUE)		Reconcili ati on	& GENERAL	
		,	, ,	DEPARTMENT		(ACCUM COST)	
				(GROSS			
		1.00	2.00	SALARI ES) 4. 00	5A	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	DA	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT	82, 090					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		833, 628				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	19, 929	14, 738	5, 729, 025	-16, 222, 019	l	
6.00	00600 MAI NTENANCE & REPAI RS	0	0	200 (40	0	651	6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0	291 0		0	721, 738 0	1
9. 00	00900 HOUSEKEEPI NG	0	834	1	Ö	520, 610	1
10.00	01000 DI ETARY	0	4, 634			251, 794	
11. 00	01100 CAFETERI A	0	0	C	0	0	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	C	0	0	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	27, 027	0	0 32, 750	13. 00 14. 00
15. 00	01500 PHARMACY	0	0			29, 240	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	Ö	2.7.00		0	ı
17.00	01700 SOCIAL SERVICE	0	0	143, 910	0	200, 247	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	
20.00	02000 NURSI NG SCHOOL	0	0	C	0	0	
21. 00 22. 00	02100 1 & R SERVICES-SALARY & FRINGES APPRV 02200 1 & R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				,		20.00
30. 00	03000 ADULTS & PEDI ATRI CS	22, 315	110, 818	1, 695, 920	0	2, 746, 620	30. 00
	ANCILLARY SERVICE COST CENTERS	07.000	150.000	1 050 1/0		7	
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	37, 090	453, 230 0		0	7, 579, 310 1, 166, 674	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 558	_	603, 659	_	826, 781	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	247, 737		0	304, 660	
60.00	06000 LABORATORY	0	0	396, 359	0	480, 288	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	33, 494	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	74 704	0	00 (22	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 198	1, 346	74, 786 565, 166		90, 622 713, 468	
69. 00	06900 ELECTROCARDI OLOGY	1,170	1, 340	303, 100	o o	950	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	2, 393, 748	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	15, 547, 855	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	565, 031	0	1, 590, 079	
	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY	0	0		0	0 132	
	07699 LI THOTRI PSY	0			1		76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	1, 073	0	1, 300	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
115 00	SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.)	T 0	0	3, 674, 411	0	13, 420, 170	115 00
118.00		82, 090	l .				
	NONREI MBURSABLE COST CENTERS	_	_		_		
194. 00 200. 00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	42, 818	0	113, 007	194. 00 200. 00
200.00	1 1						200.00
202.00	3	1, 226, 640	1, 025, 172	3, 915, 953	3	16, 222, 019	
	Part I)						
203.00		14. 942624	1. 229772	0. 211749		0. 332649	
204.00				C		1, 954, 445	204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0. 040078	205. 00
22.00							

Health Financial Systems ORTHOPAEDI C HOSPT. AT PARKVI EW In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150167 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 7:34 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE REPAI RS PLANT (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 6.00 7.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 62, 161 6.00 00700 OPERATION OF PLANT 7.00 7.00 62, 161 00800 LAUNDRY & LINEN SERVICE 8.00 0 8.00 9.00 00900 HOUSEKEEPI NG 0 62, 161 9.00 01000 DI ETARY 0000000000 30, 891 10.00 10.00 0 01100 CAFETERI A 0 0 11.00 11.00 0 Λ 01200 MAINTENANCE OF PERSONNEL 0 12.00 C 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 14.00 0 01500 PHARMACY 15.00 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 01700 SOCIAL SERVICE С 17.00 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19 00 Ω 0 02000 NURSING SCHOOL 20.00 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23 00 23.00 Ω INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30, 891 30.00 22, 315 22, 315 0 22, 315 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 37,090 37,090 0 37,090 0 50.00 05300 ANESTHESI OLOGY 0 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1,558 1,558 1, 558 0 54.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 0 C 0 0 60.00 06000 LABORATORY 0 C 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 62.00 0 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 0 C 0 0 66.00 06600 PHYSI CAL THERAPY 1, 198 1, 198 1, 198 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76 97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76.98 0 0 07699 LI THOTRI PSY 0 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 118.00 62, 161 62, 161 30, 891 118. 00 62, 161 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194. 00 0 0 0 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 868 961, 823 0 693, 790 335, 553 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.013964 15. 473094 0.000000 11. 161178 10. 862484 203. 00

26

0.000418

29. 284

0.000000

0.471099

21, 891

0.352166

15, 790 204. 00

0. 511152 205. 00

204.00

205.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Part II)

II)

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				rom 01/01/2014	D 1 /T' D	
				o 12/31/2014	Date/Time Pre 5/29/2015 7:3	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	4 (111)
cost center bescription	(MEALS SERVED)	PERSONNEL	ADMI NI STRATI ON		(COSTED	
	(MEXICO SERVED)	(NUMBER	TIDIII III STIUTTION	SUPPLY	REQUIS.)	
		HOUSED)	(DIRECT NRSING		REGUIO.	
			HRS)	REQUIS.)		
	11. 00	12. 00	13. 00	14.00	15. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 00600 MAI NTENANCE & REPAI RS						6. 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	0					11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	C				12. 00
13.00 01300 NURSING ADMINISTRATION	0	C				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	C		16, 432, 146		14. 00
15. 00 01500 PHARMACY	0	C		o	10, 000	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	C		ol	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	C		o	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	C		o	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	C		o	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	Ċ		o	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C		o	0	22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	C		o	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				-1		
30. 00 03000 ADULTS & PEDIATRICS	0	C		0	0	30.00
ANCILLARY SERVICE COST CENTERS			<u>'</u>			
50. 00 05000 OPERATING ROOM	0	C) (0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	C	ol c	o	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	ol c	o	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	ol c	o	0	58. 00
60. 00 06000 LABORATORY	0	C	o c	o	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C) c	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	o c	o	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	C	o c	o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C) c	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C) c	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C) c	16, 432, 146	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C) c	0	10, 000	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	C) c	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C) c	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	C) <u> </u>	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C) C	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C				115. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	C) <u> </u>	16, 432, 146	10, 000	118. 00
NONREI MBURSABLE COST CENTERS	_				_	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	C		0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers					00.047	201. 00
202.00 Cost to be allocated (per Wkst. B,	0	C		43, 644	38, 967	202. 00
Part I)	0 000000	0 000000	0.00000	0.002454	3. 896700	202 00
203.00 Unit cost multiplier (Wkst. B, Part I	0.000000	0. 000000	0.000000			
204.00 Cost to be allocated (per Wkst. B, Part II)		C	ر ۱	1, 313	1, 1/2	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000080	0. 117200	205 00
205.00 Unit cost multiprier (wkst. B, Part	0.000000	0. 000000	0.000000	0.000080	0.117200	200.00
	ı .		1	1	l	I

COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
			F T	rom 01/01/2014 o 12/31/2014	Date/Time Pre	nared:
			'	0 12/31/2014	5/29/2015 7:3	
					INTERNS &	
Cost Contor Doscorintian	MEDI CAL	SOCIAL SERVICE	NONDHYSI CI AN	NURSI NG SCHOOL	RESI DENTS	
Cost Center Description	RECORDS &	SOCIAL SERVICE	ANESTHETI STS	NURSI NG SCHOOL	Y & FRINGES	
	LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
	(TIME SPENT)	(TIME)	TIME)	(ASSI GNED	
					TIME)	
OFWERN OFRIGOR COOT OFWERN	16. 00	17. 00	19. 00	20. 00	21. 00	
GENERAL SERVICE COST CENTERS						1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 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 12. 00 01200 MAI NTENANCE OF PERSONNEL						11. 00 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	0					16. 00
17. 00 01700 SOCIAL SERVICE	0	10, 000				17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	C)		19. 00
20. 00 02000 NURSI NG SCHOOL	0	0		0		20.00
21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	21.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0					22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		,				25.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	10, 000		0	0	30. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0		C		-	50.00
53. 00 05300 ANESTHESI OLOGY	0	_	(1	-	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	-	54.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 60.00 O6000 LABORATORY	0				0	58. 00 60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	Ö		o o	Ö	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0				0 0	73. 00 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0				0	76. 98
76. 99 07699 LI THOTRI PSY	0	Ö		o o	Ö	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	0	0	90. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 118.00 SUBTOTALS (SUM OF LINES 1-117)	0		(115.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	U	10, 000) U	U	118. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	0	194. 00
200.00 Cross Foot Adjustments	· ·					200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	0	266, 859	C	0	0	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	1		0. 000000		
204.00 Cost to be allocated (per Wkst. B, Part II)	0	8, 025		ار ا	0	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 802500	0. 000000	0. 000000	0. 000000	205. 00
	2. 000000]	1.000000		
· · · · · · · · · · · · · · · · · · ·				'		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150167 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/29/2015 7:34 am INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER PRGM COSTS PRGM (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 22.00 23.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13. 00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16, 00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 50.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 000000000000 58.00 0 58.00 0 60.00 06000 LABORATORY 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 73 00 07697 CARDIAC REHABILITATION 76.97 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 115 00 0 0 118.00 NONREIMBURSABLE COST CENTERS 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 0 200.00 200. 00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203 00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 205.00 11)

Health Financial Systems	ORTHOPAEDI C HOS	PT. AT	PARKVI EW		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150167	Peri od: From 01/01/2014	Worksheet C	
						Date/Time Pre 5/29/2015 7:3	
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		

					10 12/31/2014	5/29/2015 7:3	
			Ti tl	e XVIII	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	
	FLENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	4, 857, 348		4, 857, 34	8 0	4, 857, 348	30. 00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	11, 088, 942		11, 088, 94		11, 088, 942	
	ANESTHESI OLOGY	1, 554, 767		1, 554, 76		1, 554, 767	ł
	RADI OLOGY-DI AGNOSTI C	1, 143, 327		1, 143, 32		1, 143, 327	
	MAGNETIC RESONANCE IMAGING (MRI)	406, 005		406, 00		406, 005	
	LABORATORY	640, 055		640, 05		640, 055	1
•	WHOLE BLOOD & PACKED RED BLOOD CELL	44, 636		44, 63	6 0	44, 636	1
	BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 06500	RESPI RATORY THERAPY	120, 767	0	120, 76	7 0	120, 767	65. 00
	PHYSI CAL THERAPY	982, 727	0	982, 72	.7	982, 727	66. 00
	ELECTROCARDI OLOGY	1, 266		1, 26		1, 266	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3, 190, 026		3, 190, 02	6 0	3, 190, 026	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	20, 763, 474		20, 763, 47	4 0	20, 763, 474	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2, 157, 984		2, 157, 98	4 0	2, 157, 984	73. 00
76. 97 0769	7 CARDIAC REHABILITATION	0			0 0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	176		17	6 0	176	76. 98
76. 99 07699	P LI THOTRI PSY	0			0 0	0	76. 99
	ATIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	1, 732		1, 73	2 0	1, 732	90. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	246, 160		246, 16	0	246, 160	92.00
SPECI	AL PURPOSE COST CENTERS						
115. 00 11500	AMBULATORY SURGICAL CENTER (D.P.)	17, 884, 376		17, 884, 37	6	17, 884, 376	115. 00
200.00	Subtotal (see instructions)	65, 083, 768	0	65, 083, 76	8 0	65, 083, 768	200. 00
201.00	Less Observation Beds	246, 160		246, 16	0	246, 160	
202.00	Total (see instructions)	64, 837, 608	0	64, 837, 60	0 8	64, 837, 608	202. 00

From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 532, 723 7, 532, 723 30.00 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 57, 854, 005 48, 299, 811 0.104461 0.000000 50.00 106, 153, 816 50.00 53.00 05300 ANESTHESI OLOGY 4.457.706 3, 395, 701 7.853.407 0. 197974 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 989, 172 1, 564, 004 0.731026 54.00 574.832 0.000000 54 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 78, 136 9, 349, 549 9, 427, 685 0.043065 0.000000 58.00 60.00 06000 LABORATORY 1, 300, 114 283, 389 1, 583, 503 0.404202 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.474851 94,000 94,000 0.000000 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 62 30 65.00 06500 RESPIRATORY THERAPY 237, 141 249, 720 486, 861 0.248052 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 2, 957, 624 2, 957, 624 0.332269 0.000000 66.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 42,602 0.029717 69.00 42, 602 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 7, 788, 107 1, 937, 792 9, 725, 899 0. 327993 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 86, 803, 119 18, 731, 624 105, 534, 743 0.196745 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 8, 770, 451 3, 059, 502 11, 829, 953 0.182417 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 Ω 76. 98 07698 HYPERBARIC OXYGEN THERAPY 200 C 200 0.880000 0.000000 76.98 07699 LI THOTRI PSY 0.000000 0.000000 76. 99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 100 140 2, 240 0.773214 0.000000 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 900 296,068 296, 968 0.828911 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 66 388 812 66, 388, 812 115 00 200.00 Subtotal (see instructions) 178, 865, 498 152, 609, 542 331, 475, 040 200.00 201.00 Less Observation Beds 201. 00

178, 865, 498

152, 609, 542

331, 475, 040

202.00

202.00

Total (see instructions)

Health Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC	CN: 150167	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 7:34 am
		T: +1 o	VVIII	Hooni tol	DDC

				5/29/2015 7:34 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	,			
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 104461			50.00
53. 00 05300 ANESTHESI OLOGY	0. 197974			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 731026			54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 043065			58. 00
60. 00 06000 LABORATORY	0. 404202			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 474851			62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 248052			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 332269			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 029717			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 327993			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 196745			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 182417			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 880000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 773214			90. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 828911			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	ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/29/2015 7:3	
		Ti t	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

						0/2//2010 /.0	i dili
			Ti t	le XIX	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		4, 857, 348		4, 857, 348	0	4, 857, 348	30.00
	ANCILLARY SERVICE COST CENTERS	,					
50.00		11, 088, 942	l .	11, 088, 942		11, 088, 942	
53. 00		1, 554, 767		1, 554, 767		1, 554, 767	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 143, 327		1, 143, 327		1, 143, 327	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	406, 005		406, 005		406, 005	
60.00	06000 LABORATORY	640, 055	l .	640, 055		640, 055	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 636		44, 636	0	44, 636	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		C	0	0	
65. 00	06500 RESPI RATORY THERAPY	120, 767	l .	120, 767		120, 767	
66. 00	06600 PHYSI CAL THERAPY	982, 727		982, 727		982, 727	66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 266		1, 266		1, 266	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 190, 026		3, 190, 026		3, 190, 026	1
72.00		20, 763, 474		20, 763, 474		20, 763, 474	
	07300 DRUGS CHARGED TO PATIENTS	2, 157, 984		2, 157, 984	0	2, 157, 984	
76. 97	07697 CARDI AC REHABI LI TATI ON	0		C	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	176		176		176	
76. 99	07699 LI THOTRI PSY	0		C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 732		1, 732		1, 732	
92.00		246, 160		246, 160		246, 160	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11500 AMBULATORY SURGICAL CENTER (D. P.)	17, 884, 376	l .	17, 884, 376		17, 884, 376	
200.00		65, 083, 768		,,		65, 083, 768	
201.00		246, 160	l .	246, 160		246, 160	
202.00	Total (see instructions)	64, 837, 608	0	64, 837, 608	0	64, 837, 608	202. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150167	Peri od: Worksheet C
		From 01/01/2014 Part I
		T- 10/01/0011 D-+-/T: D

					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/29/2015 7:3	
		_	Ti t	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	,	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	LNDATLENT DOUTLINE CERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 522 722		7 522 72	1		20.00
30. 00	03000 ADULTS & PEDIATRICS	7, 532, 723		7, 532, 72	3		30.00
FO 00	ANCILLARY SERVICE COST CENTERS	F7 0F4 00F	40, 200, 011	10/ 152 01/	0 1044/1	0.000000	FO 00
50.00	05000 OPERATING ROOM	57, 854, 005	48, 299, 811			0.000000	
53. 00	05300 ANESTHESI OLOGY	4, 457, 706	3, 395, 701			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	989, 172	574, 832			0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	78, 136	9, 349, 549			0.000000	
60.00	06000 LABORATORY	1, 300, 114	283, 389			0. 000000 0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	94, 000	0	94, 000			
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	227 141	240 720	407.07	0.000000	0.000000	
65. 00	06500 RESPI RATORY THERAPY	237, 141	249, 720			0.000000	
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 957, 624	0	2,70,702		0.000000	
		7 700 107	42, 602			0.000000	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	7, 788, 107	1, 937, 792			0.000000	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	86, 803, 119	18, 731, 624			0. 000000 0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	8, 770, 451	3, 059, 502	11, 829, 95			
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	200	0	200	0.000000	0. 000000 0. 000000	
76. 98 76. 99	07699 LI THOTRI PSY	200	0	200	0. 880000 0. 000000	0. 000000	
76. 99	OUTPATIENT SERVICE COST CENTERS	U	U		0. 000000	0.000000	76. 99
90. 00	09000 CLINIC	2, 100	140	2, 240	0. 773214	0. 000000	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	900	296, 068			0. 000000	
72.00	SPECIAL PURPOSE COST CENTERS	700	270,000	270, 700	0.020711	0.00000	72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	66, 388, 812	66, 388, 812			115. 00
200.00		178, 865, 498	152, 609, 542				200. 00
200.00		170,000,470	132, 007, 342	331, 473, 040	1		201. 00
201.00	LEGGS OBSCIVATION DCGS	1		331, 475, 040	1		1201.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT	PARKVI EW		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der (CCN: 150167	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 7:34 am
		T: +1	。 VI V	Heeni tel	DDC

				5/29/2015 7:34 am
		Title XIX	Hospi tal	PPS
Cost Center Description PPS Ir	pati ent			
	nti o			
	. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
ANCILLARY SERVICE COST CENTERS				
	0. 104461			50. 00
	0. 197974			53. 00
	0. 731026			54.00
	0. 043065			58. 00
	0. 404202			60. 00
	0. 474851			62. 00
	0. 000000			62. 30
	0. 248052			65. 00
	0. 332269			66. 00
	0. 029717			69. 00
	0. 327993			71.00
	0. 196745			72. 00
	0. 182417			73. 00
	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 880000			76. 98
	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
	0. 773214			90.00
	0. 828911			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 HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 150167	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared:

				1	0 12/31/2014	5/29/2015 7:3	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	11, 088, 942				0	00.00
	05300 ANESTHESI OLOGY	1, 554, 767				0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	1, 143, 327				0	54. 00
1	05800 MAGNETIC RESONANCE I MAGING (MRI)	406, 005		•		0	58. 00
	06000 LABORATORY	640, 055		•		0	60.00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 636	1, 342	43, 294	0	0	62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
	06500 RESPI RATORY THERAPY	120, 767		•		0	65. 00
	06600 PHYSI CAL THERAPY	982, 727		•		0	66. 00
	06900 ELECTROCARDI OLOGY	1, 266	l			0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 190, 026	95, 937	3, 094, 089	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 763, 474				0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 157, 984	64, 899	2, 093, 085	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	176	5	171	0	0	76. 98
	07699 LI THOTRI PSY	0	C	0	0	, 0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	1, 732				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	246, 160	31, 522	214, 638	0	0	92.00
[SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	17, 884, 376	537, 854	17, 346, 522	0	0	115. 00
200.00	,	60, 226, 420				•	200. 00
201.00	l e e e e e e e e e e e e e e e e e e e	246, 160	31, 522	214, 638	0	1	201. 00
202. 00	Total (line 200 minus line 201)	59, 980, 260	3, 263, 811	56, 716, 449	0	0	202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARG REDUCTIONS FOR MEDICAID ONLY	E RATIOS NET OF	Provider CCN: 150167	From 01/01/2014	Worksheet C Part II Date/Time Prepared:

					5/29/2015 7:3	34 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
			Ratio (col. 6			
	Reducti on	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	11, 088, 942		•			50.00
53. 00 05300 ANESTHESI OLOGY	1, 554, 767	7, 853, 407				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 143, 327	1, 564, 004	•			54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	406, 005	9, 427, 685	0. 043065			58. 00
60. 00 06000 LABORATORY	640, 055	1, 583, 503	0. 404202			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 636	94, 000	0. 474851			62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	120, 767	486, 861	0. 248052			65. 00
66. 00 06600 PHYSI CAL THERAPY	982, 727	2, 957, 624	0. 332269			66. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 266	42, 602	0. 029717			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 190, 026	9, 725, 899	0. 327993			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 763, 474	105, 534, 743	0. 196745			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 157, 984	11, 829, 953	0. 182417			73.00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	176	200	0. 880000			76. 98
76. 99 07699 LI THOTRI PSY	0	Ö	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLI NI C	1, 732	2, 240	0. 773214			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	246, 160	296, 968	0. 828911			92.00
SPECIAL PURPOSE COST CENTERS	•					
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	17, 884, 376	66, 388, 812	0. 269388			115. 00
200.00 Subtotal (sum of lines 50 thru 199)	60, 226, 420	323, 942, 317	,			200.00
201.00 Less Observation Beds	246, 160					201.00
202.00 Total (line 200 minus line 201)	59, 980, 260		·			202. 00

Health Financial Systems	RTHOPAEDIC HOSI	PT. AT PARKVIE	:W	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi de	r CCN: 150167	Peri od: From 01/01/2014 To 12/31/2014		pared:
		Ti	tle XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cos (col. 1 - co	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	1 0.00		0.00	
30. 00 ADULTS & PEDI ATRI CS	622, 001		0 622, 0	01 5, 604	110. 99	30. 00
200.00 Total (lines 30-199)	622, 001		622, 0	01 5, 604		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cos (col. 5 x co 6) 7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	•		_			
30. 00 ADULTS & PEDI ATRI CS	1, 705					30. 00
200.00 Total (lines 30-199)	1, 705	189, 2	38			200. 00

Heal th	Financial Systems	ORTHOPAEDIC HOS	PT AT PARKVIEW		In lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA				Peri od:	Worksheet D	1002 10
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/29/2015 7:3	pared: 4 am
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	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						
50.00	05000 OPERATI NG ROOM	1, 445, 903		1			1
53. 00	05300 ANESTHESI OLOGY	46, 758					
54.00	05400 RADI OLOGY-DI AGNOSTI C	57, 701		1			1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	316, 870					
60.00	06000 LABORATORY	19, 249		1			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 342	94, 000	1		1, 277	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	3, 632			0 213, 089		
66. 00	06600 PHYSI CAL THERAPY	49, 137	2, 957, 624	0. 01661	4 912, 361	15, 158	66. 00
69. 00	06900 ELECTROCARDI OLOGY	38	42, 602	0. 00089	2 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95, 937	9, 725, 899	0. 00986	4 2, 407, 498	23, 748	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	624, 434	105, 534, 743	0. 00591	7 25, 329, 040	149, 872	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	64, 899	11, 829, 953	0.00548	6 2, 639, 067	14, 478	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5	200	0. 02500	0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 00000	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	52	2, 240	0. 02321	4 0	0	90.00
02 00	OOOOO OPSEDVATION PEDS (NON DISTINCT DADT	21 522	206 069	0 10614	6 655	J 70	02 00

31, 522 2, 757, 479

2, 240 296, 968 257, 553, 505

0. 106146

655 50, 781, 294

0 90.00 70 92.00 467,857 200.00

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

Health Financial Systems 0	RTHOPAEDIC HOS	PT. AT	PARKVI EW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provi der		Period: From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Alli	ed Health	All Other	Swi ng-Bed	Total Costs	
	_		Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0)	0		0 0	0	30. 00
200.00 Total (lines 30-199)	0		0		0	0	200. 00
Cost Center Description	Total Patient	Per [Diem (col.	Inpatient	I npati ent		
	Days	5 ÷	col. 6)	Program Days	Program		
					Pass-Through		
					Cost (col. 7 x		
					col . 8)		
	6.00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	5, 604	Į.	0. 00	1, 70	5 0		30. 00
200.00 Total (lines 30-199)	5, 604	ļ		1, 70	5 0		200. 00

_ · · · · · · · · · · · · · · · · · · ·	RTHOPAEDIC HOS					In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S F	rovi der	CCN: 150167	Peri od:		Worksheet D	
THROUGH COSTS					From 01/ To 12/	31/2014		narod:
					10 12/	31/2014	Date/Time Pre 5/29/2015 7:3	pareu. 4 am
			Ti tl	e XVIII	Hospi	i tal	PPS	
Cost Center Description	Non Physician	Nursi n	g School	Allied Healt	h All (0ther	Total Cost	
	Anesthetist				Medi		(sum of col 1	
	Cost				Educati	on Cost		
							4)	
	1. 00	2	. 00	3. 00	4.	00	5. 00	
ANCILLARY SERVICE COST CENTERS	_		_	1	_	_		
50. 00 05000 OPERATING 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 MAGNETIC RESONANCE IMAGING (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 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								
90. 00 09000 CLI NI C	0		0		0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	0	92. 00
200.00 Total (lines 50-199)	1 0	ol .	0	1	0	0	0	200. 00

Heal th	Financial Systems (ORTHOPAEDIC HOS	PT. AT	PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PAS	S	Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 4 am
					e XVIII	Hospi tal	PPS	
	Cost Center Description	Total			Ratio of Cos		Inpati ent	
					to Charges	Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.		
		4)				7)		
	T	6. 00		7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	,						
50.00	05000 OPERATI NG ROOM	0		6, 153, 816	•			1
53.00	05300 ANESTHESI OLOGY	0		7, 853, 407	•		1, 352, 944	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		1, 564, 004	l .		458, 607	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		9, 427, 685			-	
60.00	06000 LABORATORY	0)	1, 583, 503			422, 768	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		94, 000				
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0.00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0		486, 861	0.00000	0. 000000	213, 089	65. 00
66. 00	06600 PHYSI CAL THERAPY	0) :	2, 957, 624				66. 00
69. 00	06900 ELECTROCARDI OLOGY	0		42, 602			0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0) (9, 725, 899	0.00000	0. 000000	2, 407, 498	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	10!	5, 534, 743	0.00000	0. 000000	25, 329, 040	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1	1, 829, 953	0.00000	0. 000000	2, 639, 067	73. 00
76. 97	07697 CARDIAC REHABILITATION	0		0	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		200	0. 00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0)	0	0. 00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0)	2, 240	0.00000	0. 000000	0	90.00
02 00	OOOOO OPSEDVATION PEDS (NON DISTINCT DADT		N .	206 060	0 00000	0 000000	455	02 00

2, 240 296, 968 257, 553, 505

0.000000

0.000000

90. 00 92. 00

655 50, 781, 294 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems		ORTHOPAEDI	HOSPT. AT	PARKVI EW		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE OTHE	R PASS	Provi der CCN: 15	50167	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

						5/29/2015 7:3	4 am
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	0utpa	atient	Outpati ent			
	Program	Pro	gram	Program			
	Pass-Through	Cha	rges	Pass-Through			
	Costs (col. 8			Costs (col. 9			
	x col. 10)			x col. 12)			
	11.00	12	. 00	13. 00			
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	5,	784, 436	0			50.00
53. 00 05300 ANESTHESI OLOGY	0		400, 051	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		114, 168	0			54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1,	477, 206	0			58.00
60. 00 06000 LABORATORY	0		18, 491	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 RESPIRATORY THERAPY	0		8, 118	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0		0	0			66.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		819, 161	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,	461, 179	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		353, 498	0			73.00
76. 97 07697 CARDIAC REHABILITATION	0		0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0			76. 98
76. 99 07699 LI THOTRI PSY	0		0	0			76. 99
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		0	0			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		74, 705	0			92.00
200.00 Total (lines 50-199)	0	10,	511, 013	0			200. 00

Health Financial Systems		ORTHOPAEDI C	C HOSPT. AT	PARKVI EW	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE C	COST	Provi der CCN:		Worksheet D
					From 01/01/2014	
						Doto/Time Dranamad.

				From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 104461	5, 784, 436		0	604, 248	
53. 00 05300 ANESTHESI OLOGY	0. 197974			0	79, 200	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 731026			0	83, 460	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 043065		(0	63, 616	
60. 00 06000 LABORATORY	0. 404202	18, 491	(0	7, 474	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 474851	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. 248052	8, 118	(0	2, 014	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 332269	0	(0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 029717	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 327993	819, 161	(0	268, 679	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 196745	1, 461, 179	(0	287, 480	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 182417	353, 498	(0	64, 484	73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	(0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 880000	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 773214	0	(0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 828911	74, 705	(0	61, 924	92.00
200.00 Subtotal (see instructions)		10, 511, 013		0	1, 522, 579	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		10, 511, 013	(0	1, 522, 579	202. 00
	•	•	•	•	•	

Health Financial Systems	ORTHOPAEDIC HOS	SPT. AT	PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST		Provi der	CCN: 150167		Worksheet D Part V Date/Time Pre 5/29/2015 7:3	
			Ti tl	e XVIII	Hospi tal	PPS	
·	Co	sts					
Cost Center Description	Cost Reimbursed Services	Rei i Servi	Cost mbursed ices Not				

		Ti tl	e XVIII	Hospi tal	PPS
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Servi ces Not			
	Subj ect To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS		1	·		
50. 00 05000 OPERATI NG ROOM	0	0			50. 00
53. 00 05300 ANESTHESI OLOGY	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54. 00
58.00 05800 MAGNETIC RESONANCE MAGING (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 I MPL. 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	_	1 -	ı		
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		_			000 00
202.00 Net Charges (line 200 +/- line 201)	0	0			202. 00

Health Financial Systems C	RTHOPAEDIC HOSI	PT. AT PAI	RKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Pro	ovi der		Period: From 01/01/2014 To 12/31/2014		pared: 4 am
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swi ng Adj ust		Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26) 1. 00	2.0	20	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			<i>.</i>				
30. 00 ADULTS & PEDI ATRI CS	622, 001		0	622, 00	1 5, 604	110. 99	30. 00
200.00 Total (lines 30-199)	622, 001			622, 00	1 5, 604		200. 00
Cost Center Description	Inpatient Program days	I npati Progr Capi tal (col . 5 6)	ram Cost x col.				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	171		18, 979				30.00
200.00 Total (lines 30-199)	171		18, 979	ĺ.			200. 00

		RTHOPAEDIC HOS				u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narod:
					10 12/31/2014	5/29/2015 7:3	pareu. 4 am
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 445, 903	106, 153, 816	0. 01362	1, 892, 017	25, 771	50.00
53.00	05300 ANESTHESI OLOGY	46, 758	7, 853, 407	0.00595	151, 189	900	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	57, 701	1, 564, 004	0. 03689	45, 983	1, 696	54. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	316, 870	9, 427, 685	0. 03361	1 9, 649	324	58. 00
60.00	06000 LABORATORY	19, 249	1, 583, 503	0. 01215	42, 451	516	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 342	94, 000	0. 01427	7 4, 036	58	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	3, 632	486, 861	0. 00746	23, 628	176	65.00
66.00	06600 PHYSI CAL THERAPY	49, 137	2, 957, 624	0. 01661	4 94, 926	1, 577	66.00
69.00	06900 ELECTROCARDI OLOGY	38	42, 602	0. 00089	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95, 937	9, 725, 899	0. 00986	260, 725	2, 572	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	624, 434	105, 534, 743	0. 00591	7 2, 786, 114	16, 485	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	64, 899	11, 829, 953	0. 00548	313, 243	1, 718	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	5	200	0. 02500	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 CLI NI C	52	2, 240	0. 02321	4 0	0	90. 00
02 00	00200 OBSEDVATION PEDS (NON DISTINCT DADT	21 522	206 069	0 10614	210	1 22	02 00

31, 522 2, 757, 479

2, 240 296, 968 257, 553, 505

0. 106146

210 5, 624, 171

0 90.00 22 92.00 51,815 200.00

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

Health Financial Systems 0	RTHOPAEDIC HOSI	PT. AT	PARKVI EW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 4 am
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allie	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0		0		0 0	0	30.00
200.00 Total (lines 30-199)	0		0		0	0	200. 00
Cost Center Description	Total Patient	Per D	iem (col.	I npati ent	I npati ent		
	Days	5 ÷	col. 6)	Program Days	Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	5, 604		0. 00	17	1 0		30.00
200.00 Total (lines 30-199)	5, 604			17	1 0		200. 00

<u> </u>	ORTHOPAEDIC HOSI				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider	CCN: 150167	Peri od: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2014		nared.
					5/29/2015 7:3	
			le XIX	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	_	1	.1		_	
50. 00 05000 OPERATI NG ROOM	0	()	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	()	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	()	0	0	54. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	()	0	0	58. 00
60. 00 06000 LABORATORY	0	()	0	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	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(0	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	[()	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	(0	1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(0	0	
200.00 Total (lines 50-199)	0	()	0	0	200. 00

		ORTHOPAEDIC HOS					u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S	Provi der		Peri od:	Worksheet D	
THROUG	H COSTS					From 01/01/2014 To 12/31/2014	Part IV Date/Time Prep	narod:
						10 12/31/2014	5/29/2015 7: 3	uareu. 4 am
				Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Tota	l Charges	Ratio of Cos		Inpati ent	
	'	Outpati ent		n Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part	I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and		8)	7)	(col. 6 ÷ col.	_	
		4)				7)		
		6.00		7.00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	10	6, 153, 816	0.00000	0. 000000	1, 892, 017	50.00
53.00	05300 ANESTHESI OLOGY	0		7, 853, 407	0.00000	0. 000000	151, 189	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		1, 564, 004	0.00000	0. 000000	45, 983	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		9, 427, 685	0.00000	0. 000000	9, 649	58. 00
60.00	06000 LABORATORY	0		1, 583, 503	0.00000	0. 000000	42, 451	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		94, 000	0.00000	0. 000000	4, 036	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0.00000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0		486, 861	0.00000	0. 000000	23, 628	65.00
66.00	06600 PHYSI CAL THERAPY	0		2, 957, 624	0.00000	0. 000000	94, 926	66. 00
69.00	06900 ELECTROCARDI OLOGY	0		42, 602	0.00000	0. 000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		9, 725, 899	0.00000	0. 000000	260, 725	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	10	5, 534, 743	0.00000	0. 000000	2, 786, 114	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1	1,829,953	0.00000	0. 000000	313, 243	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		0	0.00000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		200	0. 00000	0. 000000	0	76. 98
76. 99	07699 LI THOTRI PSY	0		0	0.00000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0		2, 240	0.00000	0. 000000	0	90. 00
92 00	00200 OBSEDVATION PEDS (NON DISTINCT DADT	1	1	206 060	0 00000	0 000000	210	02 00

2, 240 296, 968 257, 553, 505

0.000000

0.000000

0 90.00 210 92.00

5, 624, 171 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50-199)

Health Financial Systems		ORTHOPAE	EDIC HOSPT.	T PARKVI EW		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVI CE 01	THER PASS	Provi der	CCN: 150167	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

				5/29/2015 7:3	4 am	
	Ti t	le XIX	Hospi tal	PPS		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0			50.00
53. 00 05300 ANESTHESI OLOGY	0	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0			54.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0			58. 00
60. 00 06000 LABORATORY	0	0	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 RESPIRATORY THERAPY	0	0	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0			76. 98
76. 99 07699 LI THOTRI PSY	O	0	0			76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0			90. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	0			92. 00
200.00 Total (lines 50-199)	0	0	0			200. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150167	Peri od:	Worksheet D

From 01/01/2014 Part V To 12/31/2014 Date/Time Prepared: 5/29/2015 7:34 am Title XIX Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 104461 5, 403, 975 0 50.00 53.00 05300 ANESTHESI OLOGY 0. 197974 371, 682 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 731026 0 109, 104 54 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.043065 695, 980 0 58.00 60.00 06000 LABORATORY 0. 404202 19, 335 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.474851 0 0 62.00 O 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0. 248052 6, 456 0 65.00 06600 PHYSI CAL THERAPY 3, 933 66.00 0. 332269 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0.029717 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 327993 754, 769 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 196745 1, 132, 600 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.182417 336, 416 73.00 0 07697 CARDIAC REHABILITATION 76.97 0 0 0.000000 Ω 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.880000 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 773214 0 90.00 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.828911 677 0 92.00 200.00 Subtotal (see instructions) 8, 834, 927 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 +/- line 201) 0 202.00 202.00 0 8, 834, 927

Health Financial Systems		PARKVI EW		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OT	THER HEALTH SERVICES	AND VACCINE	COST	Provi der CCN:	150167	Peri od: From 01/01/2014	Worksheet D
							Dato/Timo Propared:

				To 12/31/2014		
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS		_				
50. 00 05000 OPERATI NG ROOM	564, 505	0)			50. 00
53. 00 05300 ANESTHESI OLOGY	73, 583	0)			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	79, 758	0)			54. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	29, 972	0)			58. 00
60. 00 06000 LABORATORY	7, 815	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	1, 601	0)			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 307	0)			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	247, 559	0)			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	222, 833	0)			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	61, 368	0	2			73. 00
76. 97 O7697 CARDIAC REHABILITATION	0	0	2			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	1			76. 98
76. 99 07699 LI THOTRI PSY	0	0)			76. 99
OUTPATIENT SERVICE COST CENTERS			.1			
90. 00 09000 CLI NI C	0	0	2			90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	561	0	2			92.00
200.00 Subtotal (see instructions)	1, 290, 862	0	'			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	1 200 0/2					202 00
202.00 Net Charges (line 200 +/- line 201)	1, 290, 862	0	יו			202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150167	Peri od: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre 5/29/2015 7:3	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					Ī

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 604	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		vato room days	5, 604 0	2. 00 3. 00
3.00	do not complete this line.). If you have only pri	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		5, 320	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December (21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) after becember .	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 705	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions Swing-bed SNF type inpatient days applicable to title XVIII only		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		Join days) arter	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	anly (including private	a maam daya)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			Ü	13. 00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 of	f the cost	0.00	17. 00
17.00	reporting period	thi dugit becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00
10.00	reporting period	+h	*	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 or	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost reporti	ng poriod (Line	4, 857, 348 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost reporti	ng perrou (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportino	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
	Total swing-bed cost (see instructions)	: 21 1: 2()		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus iine 26)		4, 857, 348	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)	>		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	line 28)		0. 000000 0. 00	31. 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 minu	s line 33)(see instruct	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	d privata room cost did	Eforontial (1:	0 4 957 349	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	u private room cost dit	rrerential (line	4, 857, 348	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST				
38. 00	Adjusted general inpatient routine service cost per diem (see i	,		866. 76	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			1, 477, 826 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	,		1, 477, 826	
		•	,		

Cost Center Description	Heal th	Financial Systems 0	RTHOPAEDI C HOSI	PT.AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
STATE STAT						Peri od:		
Cost Center Description								
1.09 MUSSINY (11tle V 8.78% entry)		Cost Center Description	Total			<u>' </u>	+'	
1.00 PURSERY (Little V a XIX only) 1.00 2.00 3.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 5.00 4.00 5.0		·	Inpatient Cost		Diem (col. 1			
Internsive Care Type Imputiont Respitation (15 to 15	42.00	NUDCEDY (+: +1 - 1/ 0 VIV1 -)	1.00	2.00		4. 00		42.00
43.00 INTERSIVE CARE UNIT 44.00	42.00							42.00
45.00 SIRRIO LANTENSIVE CARE UNIT 45.00		INTENSIVE CARE UNIT						1
4-0.00								
1.00								1
1.00		OTHER SPECIAL CARE (SPECIFY)						1
Program inpatient ancillary service cost (Misst D-3, col. 3, line 200) 9, 196, 817 48.00 Program inpatient costs (sum of lines 41 through 48) (See Instructions) 10, 674, 643 49.00 Program inpatient costs (sum of lines 41 through 48) (See Instructions) 10, 674, 643 49.00 Program inpatient costs (sum of lines 50 and 51) 50.00 Program inpatient poerating ost excluding capital related, non-physician anesthetist, and and (sum of lines 50 and 51) 50.00 Total Program inpatient operating osst excluding capital related, non-physician anesthetist, and edical education costs (line 40 minus line 59) 50.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and edical education costs (line 40 minus line 59) 50.00 50.		Cost Center Description					1 00	
180, 236 50.00 110		Total Program inpatient costs (sum of lines			ons)		9, 196, 817	1
51.00 Pass through costs applicable to Program inpatient ancillary services (From Wikst. 0, sum of Parts II and IV) A67,857 51.00 and IV) A67,095 52.00 Total Program excludable cost (sum of lines 50 and 51) A67,095 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 10,017,548 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 10,017,548 53.00 Total Readount (line 54 x line 49 minus line 52) A67,000 A6	50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	m of Parts I and	189, 238	50. 00
10 10 10 10 10 10 10 10	51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D,	sum of Parts II	467, 857	51. 00
medical education costs (line 49 minus line 52)		Total Program excludable cost (sum of lines		lated non re-	sicion cost	antist and		1
54.00 Program discharges 0.0 54.00 55.00 Target amount per discharge 0.00 55.00 56.00 Target amount (line 54 x line 55) 0.06 55.00 56.00 57.00 5	53.00	medical education costs (line 49 minus line	9 1	erated, non-pny	ysician anesti	netist, and	10, 017, 548	53.00
56.00 Target amount (line 54 x line 55) 0.56.00 55.00	54. 00						0	54. 00
57.00 bifference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 bis payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55,50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (line 12 x line 19) 68.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Skilled ours are skilled NF inpatient routine costs (line 67 + line 2) 70.00 Skilled ours are skilled NF inpatient routine service cost (line 7 + line 2) 71.00 Adjusted general inpatient routine service costs (line 7 + line 2) 72.00 Program routine service cost (line 7 + line 7) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 77 + line 78) 75.00 Capital-related costs								1
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 61.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relicef payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Relicef payment (see instructions) 65.00 Relicef payment (see instructions) 65.00 Relicef payment (see instructions) 65.00 Relicera swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt V XVIII only) 65.00 Redicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilte XVIII only). For CAM (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilte XVIII only). For CAM (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tilte XVIII only). For CAM (see instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PARTIII - SKILLED NURSING FACILITY, Offler NUSING FACILITY, Allowed NF (line 37) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Program routine service cost (line 9 x line 71) 60.00 From the service cost (line 9 x line 71) 60.00 From market and the service cost (line 9 x line 71) 60.00 Total Program general inpatient routine service costs (from Morksheet B, Part II, column Capital Program capital related costs (line 74 minus line 7			ing cost and ta	arget amount (1	ine 56 minus	line 53)	1	1
market basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relider payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) till eXVII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) till eXVII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, Offer NURSING RACILITY, Offer NURSING		, , , , , , , , , , , , , , , , , , , ,	ring cost and te	inger amount (i	THE 50 III HGS	11110 33)	1	
60.00 Lesser of lines \$3/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 fol.00 line \$3.55	59. 00		porting period	endi ng 1996, เ	updated and co	ompounded by the	0.00	59. 00
61.00 If I line 53/54 is less than the lower of lines 55. 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relice fip apyment (see instructions) 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XWIII only) 65.00 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XWIII only) 66.00 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title VI vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/ot	60. 00		cost report. ur	odated by the r	market basket		0.00	60.00
amount (Ilne 56), otherwise enter zero (see instructions) 0 62.00		If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of	•		1
62.00 Relief payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) (Inte V or XIX swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 9 x line 71) 71.00 Algusted general inpatient routine service costs (line 12 x line 23) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74.00 Total Program general inpatient routine service costs (from Program Worksheet B, Part II, column 26, line 45) 75.00 Program coutine service cost (line 75 + line 2) 77.00 Program coutine service cost (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service costs (see instructions) 79.00 Reasonable inpatient ancillary services (see instructions) 79.00 Reasonable inpatient routine								
PROGRAM INPATIENT ROUTINE SWING BED COST	62. 00		riisti ucti olis)				0	62. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). 67.00 Total Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 71.00 72.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 73.00 74.00 75.00 76.0	63. 00		ent (see instru	uctions)			0	63. 00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 10tal Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 67.00 10tal Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 11tle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 11tle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 69.00 10tal title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 69	64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Agusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Resonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 78.00 Total Program inpatient routine service costs (see instructions) 86.00 Tot	65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the o	cost reportino	g period (See	0	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Villization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00
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69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [December 31 of	the cost repo	orting period	0	68. 00
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89.00 Observation bed cost (line 87 x line 88) (see instructions) 246,160 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				866. 76	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (se	e instructions)				246, 160	89. 00

Health Financial Systems	ORTHOPAEDIC HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Prep 5/29/2015 7:3	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	622, 001	4, 857, 348	0. 12805	4 246, 160	31, 522	90.00
91.00 Nursing School cost	0	4, 857, 348	0.00000	246, 160	0	91.00
92.00 Allied health cost	0	4, 857, 348	0.00000	246, 160	0	92.00
93.00 All other Medical Education	0	4, 857, 348	0.00000	246, 160	0	93.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT	PARKVI EW	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150167	Peri od: From 01/01/2014	Worksheet D-1		
			To 12/31/2014	Date/Time Pre 5/29/2015 7:3	pared: 4 am	
		Title XIX	Hospi tal	PPS		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room	Inpatient days (including private room days and swing-bed days, excluding newborn) 5,604					

MAIL 1 = ALL PROFIDER COMPONENTS		Cost Center Description		
Impart Incidence		DADT I ALL DROWLDED COMPONENTS	1. 00	
Inpatt ent days (Including private room days and swing-bed days, excluding newborn) 5,604 2.00				
Impatient days (including private room days, excluding swing-bed and newborn days) 15,004 2.00 3.00 Private room days (seculating swing-bed and observation bed days). If you have only private room days (so do not complete this line 3.00 15.00 3.00 4.00 4.00 3.00 4.	1.00		5, 604	1. 00
do not complete this line. 4. OS Self-private room days (excluding swing-bed and observation bed days) 5.00 Intal swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. OD Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. OD Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. OD Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. OD Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. OD Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and next on the program (excluding swing-bed and next on the swing-bed SW type inpatient days applicable to the program (excluding private room days) 9. OD Swing-bed SWF type inpatient days applicable to the Program (excluding private room days) 11. OD Swing-bed SWF type inpatient days applicable to the program (excluding private room days) 12. OD Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) 13. OD Swing-bed SWF type inpatient days applicable to title SWIII only (including private room days) 14. OD Swing-bed SWF type inpatient days applicable to title SWIII only (including private room days) 15. OD Swing-bed SWF type inpatient days applicable to title SWF or XX only (including private room days) 16. OD Swing-bed NF type inpatient days applicable to swing-bed SWF applicable to swing-b				
Semi-private room days (excluding sating-bed and observation bed days) 5.00 Total sing-bed SkY type inpartient days (including private room days) after December 31 of the cost 7.00 Total sing-bed NF type inpartient days (including private room days) after December 31 of the cost 8.00 Total sating-bed NF type inpartient days (including private room days) after December 31 of the cost 8.00 Total sating-bed NF type inpartient days (including private room days) after December 31 of the cost 8.00 Total sating-bed NF type inpartient days (including private room days) after December 31 of the cost 9.00 Total inpartient days including private room days) after December 31 of the cost 9.00 Total inpartient days including private room days applicable to the Program (excluding swing-bed and 9.00 Total inpartient days applicable to the Program (excluding private room days) 9.00 Total inpartient days applicable to the Program (excluding private room days) 9.00 Total inpartient days applicable to the Program (excluding private room days) 9.00 Swing-bed NF type inpartient days applicable to the Program (excluding private room days) 9.01 Total Inpartient days applicable to title sW Into War only (including private room days) 9.02 Total program (excluding private room days) 9.03 Swing-bed NF type inpartient days applicable to title sW Into War only (including private room days) 9.04 Swing-bed NF type inpartient days applicable to the Program (excluding private room days) 9.05 Swing-bed NF type inpartient days applicable to services after December 31 of the cost 9.00 Total unsersy days (title V or XIX only) 9.01 Swing-bed NF type inpartient days applicable to services after December 31 of the cost 9.00 Swing-bed NF type inpartient days applicable to services after December 31 of the cost 9.00 Swing-bed NF services applicable to services after December 31 of the cost 9.00 Swing-bed NF services applicable to services after December 31 of the cost 9.00 Swing-bed cost applicable to NF type services after December 31 of the cost repor	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,		3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Potal swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) through December 31 of the cost of Potal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if realendar year, enter 0 on this line)		do not complete this line.		
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reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost 8.00 Total saing-bed Mr type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 171 newtorn days) 10.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) after 11.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) after 12.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) after 13.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 14.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 15.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 16.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 17.00 Swing-bed SMr type inpatient days applicable to XVIII only (including private room days) 18.00 Swing-bed SWr type inpatient days applicable to XV only (including private room days) 18.00 Swing-bed SWr type inpatient days applicable to XV only (including private room days) 18.00 Swing-bed SWr type swing-bed SWr type services applicable to Services through December 31 of the cost 18.00 Swing-bed SWr type inpatient days applicable to Services through December 31 of the cost 18.00 Swing-bed SWr type services applicable to services after December 31 of the cost 18.00 Swing-bed SWr type services applicable to services after December 31 of the cost 18.00 Swing-bed Cost applicable to SWr type services through December 31 of the cost reporting period (line 6				/ 00
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reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Sking-bed SMb type inpatient days applicable to title XVIII only (including private room days) 11.00 Sking-bed SMb type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Sking-bed SMb type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Sking-bed SMb type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Includin ursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total care rate for swing-bed SMF services applicable to services through December 31 of the cost 0.00 17.00 Medical care rate for swing-bed SMF services applicable to services after December 31 of the cost 0.00 18.00 reporting period (including period 0.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 18.00 reporting period 0.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 0.00 18.00 19.00 Swing-bed cost applicable to SMF type services through December 31 of the cost reporting period (line 0.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 0.0	7 00		0	7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line)	7.00		ا	7.00
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				

Heal th	Financial Systems (ORTHOPAEDIC HOS	PT.AT PARKVIFM	1	In lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST	SKITIOI ALDI C 1103		CCN: 150167	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
			Ti	tle XIX	Hospi tal	5/29/2015 7: 3 ² PPS	4 am
	Cost Center Description	Total	Total	Average Per	·	Program Cost	
	·	Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	2.00	3. 00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	· ·	I	T			43.00
44. 00							44. 00
45. 00	1						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 1, 009, 066	48. 00
	Total Program inpatient costs (sum of lines			ons)		1, 157, 282	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	natient routine	services (fro	m Wkst D su	m of Parts I and	18, 979	50.00
	111)		·				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	51, 815	51.00
52. 00	Total Program excludable cost (sum of lines					70, 794	52. 00
53. 00			elated, non-ph	ysician anest	hetist, and	1, 086, 488	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00						0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00
58. 00 59. 00	, ,	porting ported	onding 1006	undated and c	omnounded by the	0 00	58. 00 59. 00
39.00	market basket	portring perrod	ending 1770,	upuateu anu c	ompounded by the	0.00	39.00
60. 00 61. 00						0. 00 0	60. 00 61. 00
61.00	which operating costs (line 53) are less that					U	61.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)			-		(2.00
62. 00 63. 00	, ,	ment (see instru	uctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	ember 31 of th	e cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	oer 31 of the	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVI	II only) For	0	66. 00
00.00	CAH (see instructions)	•	•	, ,	3,		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	n December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 ± lin	e 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	/, AND ICF/MR	ONLY			07.00
70. 00 71. 00							70. 00 71. 00
71.00	, ,		THE 70 + THE	2)			72.00
73.00	1 3 1						73.00
74. 00 75. 00		•		,	Part II. column		74. 00 75. 00
	26, line 45)						
76. 00 77. 00							76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	ıs line 77)					78. 00
79. 00	93 3 3	, ,		*.	nus lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		JUST TIMITATIO	ii (iiile /8 Mi	ilus IIIle /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 8	* .				82. 00
83. 00 84. 00	•		ns)				83. 00 84. 00
85. 00			ons)				85. 00
86. 00			nrough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					284	87. 00
88. 00		•				866. 76	
07. 00	Observation bed cost (line 87 x line 88) (se	e instructions)	,			246, 160	I 07. UU

Health Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
	_	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	622, 001	4, 857, 348	0. 12805	4 246, 160	31, 522	90.00
91.00 Nursing School cost	0	4, 857, 348	0.00000	246, 160	0	91.00
92.00 Allied health cost	0	4, 857, 348	0.00000	246, 160	0	92.00
93 00 All other Medical Education	1	4 857 348	0.00000	246 160	0	93 00

Heal th	Financial Systems ORTHOPAEDIC HOSPT.AT	PARKVI EW		In Li∈	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150167	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 7:3	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs (col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3, 00	
	I NPATIENT ROUTINE SERVICE COST CENTERS		•		•	
30.00	03000 ADULTS & PEDI ATRI CS			2, 193, 346		30.00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 1044			1
53.00	05300 ANESTHESI OLOGY		0. 1979			1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 7310			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0430			
60.00	06000 LABORATORY		0. 40420			
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 4748!			62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62. 30
65.00	06500 RESPI RATORY THERAPY		0. 2480			65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 3322		303, 149	
69. 00	06900 ELECTROCARDI OLOGY		0. 0297			69. 00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 3279			1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1967			1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1824		481, 411	1
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 00000		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0. 88000		0	76. 98
76. 99	07699 LITHOTRI PSY OUTPATI ENT SERVI CE COST CENTERS		0.0000	00 0	0	76. 99
90. 00	09000 CLINIC		0. 7732	14 0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.7732			92.00
200.00			0.0209	50, 781, 294		
200.00		ina 61)		50, 761, 294		200.00
201.00		1116 01)		50, 781, 294	l	201.00
202.00	I met onarges (Title 200 IIII lius Title 201)		1	30, 701, 274	I	1202.00

Heal th	Financial Systems ORTHOPAEDIC HOSPT. AT	PARKVI EW		In Li∈	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150167	Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/29/2015 7:3	pared: 4 am
		Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATI ENT DOUTING CEDVI OF COCT CENTEDS		1.00	2. 00	3. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			217, 005		30.00
30.00	ANCI LLARY SERVI CE COST CENTERS			217,005		30.00
50 00	05000 OPERATING ROOM		0. 1044	1, 892, 017	197, 642	50.00
	05300 ANESTHESI OLOGY		0. 1979			
	05400 RADI OLOGY-DI AGNOSTI C		0. 7310			
	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0430			
	06000 LABORATORY		0. 40420			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 4748!			
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62. 30
65.00	06500 RESPI RATORY THERAPY		0. 2480	52 23, 628	5, 861	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 3322	59 94, 926	31, 541	
69. 00	06900 ELECTROCARDI OLOGY		0. 0297		0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3279			1
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1967			1
	07300 DRUGS CHARGED TO PATIENTS		0. 1824			73. 00
	07697 CARDI AC REHABI LI TATI ON		0.00000		0	
	07698 HYPERBARI C OXYGEN THERAPY		0.88000		0	
76. 99	07699 LI THOTRI PSY		0.0000	00 0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS		0.7700	1.4		00.00
	09000 CLINIC		0. 7732			90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 8289			
200. 00 201. 00		ino 61)		5, 624, 171 0		200. 00
201.00		1116 01)		5, 624, 171	l	201.00
202.00	Incr onarges (True 200 III has True 201)		1	J, UZ4, 171	I	1202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150167	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/29/2015 7:3	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1. 00	2. 00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	a nrior		5, 983, 298	l	1. 00
	to October 1 (see instructions)					
1. 02	DRG amounts other than outlier payments for discharges occurrin after October 1 (see instructions)	g on or		2, 302, 236		1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions)			0		1. 04
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.04
2.00	Outlier payments for discharges. (see instructions)			113, 577		2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2. 01 2. 02
3.00	Managed Care Simulated Payments	113)		0		3. 00
4.00	Bed days available divided by number of days in the cost report	i ng		36. 22		4. 00
	period (see instructions) Indirect Medical Education Adjustment					-
5.00	FTE count for allopathic and osteopathic programs for the most	recent		0.00		5. 00
	cost reporting period ending on or before 12/31/1996. (see instr	,		0.00		/ 00
6. 00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordance			0.00		6. 00
	CFR 413.79(e)					
7. 00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7. 00
7. 01	CFR $\S412.105(f)(1)(iv)(B)(1)$ ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July					
8. 00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8.00
6.00	osteopathic programs for affiliated programs in accordance with			0.00		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s undar		0.00		8. 01
0.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
	instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the curren	t voar		0.00		10.00
10.00	from your records	t year		0.00		10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	l .	11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0. 00 0. 00	l	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
	or after September 30, 1997, otherwise enter zero.					
15.00	Sum of lines 12 through 14 divided by 3.			0.00	l .	15. 00
17. 00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closur	e		0. 00 0. 00	l	16. 00 17. 00
18. 00	Adjusted rolling average FTE count	C		0.00	l e	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	l e	19. 00
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000		20. 00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000		21.00
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22. 00 22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for Section	n 422 of t	he MMA]
23. 00	Number of additional allopathic and osteopathic IME FTE residen	t cap		0.00		23. 00
24. 00	slots under 42 Sec. 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo	wer of		0.00		25. 00
24 00	line 23 or line 24 (see instructions)			0.000000		24 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			1 0	<u> </u>	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		0.00		30.00
31. 00	(see instructions) Percentage of Medicaid patient days (see instructions)			3. 28		31.00
31.00	Sum of Lines 30 and 31			3. 28		31.00
33. 00	Allowable disproportionate share percentage (see instructions)			0.00	l e	33. 00
34. 00	Disproportionate share adjustment (see instructions)		I	0		34.00

			Го 12/31/2014	Part A Date/Time Pre 5/29/2015 7:3	
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
1	Total uncompensated care amount (see instructions)		9, 046, 380, 143		
	Factor 3 (see instructions)		0. 000004337	0. 000004111	
35. 02	Hospital uncompensated care payment (If line 34 is zero,		0	0	35. 02
	enter zero on this line) (see instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment		0	0	35. 03
0, 00	amount (see instructions)				0, 0,
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		0		36.00
	35.03) Additional payment for high percentage of ESRD beneficiary di	ischarges (Lines 40 through	141		
	Total Medicare discharges on Worksheet S-3, Part I	rscharges (Triles 40 till ough	0		40.00
+0.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and		J J		40.00
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
11.00	682, 683, 684 an 685. (see instructions)				11.00
41. 01	Total ESRD Medicare covered and paid discharges excluding		o		41. 01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
ļ	682, 683, 684 an 685. (see instructions)				
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
	divided by line 41 divided by 7 days)				
45. 00	Average weekly cost for dialysis treatments (see		0.00		45.00
47 00	instructions)				47.00
46. 00	Total additional payment (line 45 times line 44 times line 41.01)		U		46.00
47. 00	Subtotal (see instructions)		8, 399, 111		47.00
	Hospital specific payments (to be completed by SCH and		0, 377, 111		48.00
+0.00	MDH, small rural hospitals only. (see instructions)		J		40.00
49. 00	Total payment for inpatient operating costs (see		8, 399, 111		49.00
. ,	instructions)		0,0,,,		17.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		666, 687		50.00
	and Pt. II, as applicable)				
51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
ļ	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52. 00
	line 49 see instructions).				F0 00
	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0		53. 00 54. 00
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
35.00	line 69)		٩		33.00
56. 00	Cost of physicians' services in a teaching hospital (see		0		56.00
, , , ,	intructions)				00.00
57. 00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		0		58. 00
	Pt. IV, col. 11 line 200)				
1	Total (sum of amounts on lines 49 through 58)		9, 065, 798		59.00
	Primary payer payments		0		60.00
61. 00	Total amount payable for program beneficiaries (line 59		9, 065, 798		61.00
62. 00	minus line 60)		772 240		(2.00
	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries		773, 248		62. 00 63. 00
	Allowable bad debts (see instructions)		-448		64.00
	Adjusted reimbursable bad debts (see instructions)		-291		65. 00
	Allowable bad debts for dual eligible beneficiaries (see		-10, 279		66. 00
30. 00	instructions)		10, 277		00.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8, 292, 259		67. 00
	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
	96). (For SCH see instructions)				_
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
1	RURAL DEMONSTRATION PROJECT		0		70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
70.00	instructions) USD bonus payment HVPD adjustment amount (see				70.00
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)		"		70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)				70. 91
	Bundled Model 1 discount amount (see instructions)				70. 92
	HVBP payment adjustment amount (see instructions)		19, 223		70. 93
1	HRR adjustment amount (see instructions)		0		70. 94
70. 95	Recovery of accelerated depreciation		o		70. 95

	Financial Systems ORTHOPAEDIC HOSE			u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150167	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 5/29/2015 7:3	pared: 4 am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0 0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0 0		70. 97
70. 98	Low Volume Payment-3		0		70. 98
70. 99	HAC adjustment amount (see instructions)		0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8, 311, 482		71. 00
71. 01	Sequestration adjustment (see instructions)		166, 230		71. 01
72.00	Interim payments		8, 145, 537		72. 00
73.00	Tentative settlement (for contractor use only)		0		73. 00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-285		74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0		93. 00
94. 00	The rate used to calculate the time value of money (see instructions)		0.00		94. 00
95. 00	Time value of money for operating expenses (see instructions)		0		95. 00
96. 00	Time value of money for capital related expenses (see instructions)		0		96. 00

		00	
HSP Bonus Payment Amount			
HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
HVBP adjustment factor (see instructions)	0		101. 00
HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00
	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) 0.0000	HSP bonus amount (see instructions) 0 0 HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) 0 0 HVBP adjustment amount for HSP bonus payment (see instructions) 0 0 HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) 0.0000 0.0000

Pri or to 10/1 On/After 10/1 1.00 2.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARI	ARKVI EW	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Prov	ovider CCN: 150	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 7:34 am

			10 12/31/2014	5/29/2015 7:3	
		Title XVIII	Hospi tal	PPS	T GIII
			<u>'</u>		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	`		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		1, 522, 579 1, 621, 285	
3. 00 4. 00	PPS payments Outlier payment (see instructions)			1, 621, 285	
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
6. 00	Line 2 times line 5	10113)		0.000	
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col. 13, line 200		0	9.00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
40.00	Reasonable charges				10.00
12.00	Ancillary service charges	4.		0	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co Total reasonable charges (sum of lines 12 and 13)	1. 4)		0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	a charge basis	0	15. 00	
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		3		
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	18. 00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19.00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see</pre>	instructions)		0	21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instru	rtions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	311 0113)		1, 678, 681	
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1, 0, 0, 00 1	1 00
25.00	Deductibles and coinsurance (for CAH, see instructions)			345, 978	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		0	
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (for	1, 332, 703	27.00
	CAH, see instructions)	50)			
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			1 222 702	
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 332, 703 0	1
32. 00				1, 332, 703	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		1,002,700	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	- /		0	33.00
34.00	Allowable bad debts (see instructions)			45, 253	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			29, 414	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		37, 993	
	Subtotal (see instructions)			1, 362, 117	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	u uevices (see instruc	u ons)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			1 262 117	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			1, 362, 117 27, 242	
41. 00	Interim payments			1, 306, 049	
42. 00	Tentative settlement (for contractors use only)			1, 300, 047	
43. 00	Balance due provider/program (see instructions)			28, 826	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2		· · · · · · · · · · · · · · · · · · ·		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91. 00	1			0	
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00
					1 4/1 ()

| Period: | Worksheet E-1 | From 01/01/2014 | Part | Date/Time Prepared: | 5/29/2015 7:34 am Health Financial Systems ORTHOP
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150167

					5/29/2015 7:3	4 am
			le XVIII	Hospi tal	PPS	
		Inpatie	ent Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		8, 145, 537		1, 306, 049	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider		1			2 01
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3. 02			1		0	3. 02
3. 03			C		_	3. 03
3.04			0		0	3. 04
3. 05	Describer to Describe				0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			1	0	3. 50
3. 50	ADJUSTWENTS TO PROGRAW				0	3. 50
3. 51					0	3. 51
3. 52					0	3. 52
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 145, 537		1, 306, 049	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 1.0,007		1,000,017	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		_			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			0		0	5. 02
5. 03			C		0	5. 03
	Provider to Program			1	1	
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
4 00	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				28, 826	6. 01
6. 02	SETTLEMENT TO PROGRAM		285		20, 020	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 145, 252		1, 334, 875	
7.00	Trotal modicale program trability (see Histructions)		0, 140, 202	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	I I			1		

Heal th	Financial Systems 0	RTHOPAEDIC HOSPT. AT	PARKVI EW		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN:	: 150167	Peri od:	Worksheet E-1	
					From 01/01/2014		
					To 12/31/2014		
			Title XV	/1.1.1	Hospi tal	5/29/2015 7: 3 ² PPS	4 am
			II tie xv	/111	Hospi tal	I PPS	
						1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NOW OTANDA	D. COOT DEPOSTS				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDAR						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION						
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			2, 194			
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1, 705	2. 00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col.					1, 233	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 :	sum of lines 1, 8-12	2			5, 320	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200				331, 475, 040	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20			647, 387	6.00			
7.00	CAH only - The reasonable cost incurred for	the purchase of cert	tified HIT tec	chnol ogy	Wkst. S-2, Pt. I	0	7.00
	line 168						
8.00	Calculation of the HIT incentive payment (see	e instructions)				611, 120	8.00
9.00	Sequestration adjustment amount (see instruc	tions)				12, 222	9.00
10.00	Calculation of the HIT incentive payment after		ee instruction	ns)		598, 898	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH						
30.00	Initial/interim HIT payment adjustment (see	instructions)				582, 617	30.00
31. 00	Other Adjustment (specify)	ŕ				0	31.00
22 00	, , , , , , , , , , , , , , , , , , , ,	nua lina 20 and lina	21) (222 inc	+=====	-)	17 201	22 00

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

582, 617 30. 00 0 31. 00 16, 281 32. 00

Health Financial Systems ORTHOPAEDIC HOSPT.

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

Provi der CCN: 150167 | Peri od: From 01/01/2014 To 12/31/2014

Worksheet G
Date/Time Prepared: 5/29/2015 7:34 am

		General Fund	Speci fi c	Endowment Fund	Plant Fund	4 all
			Purpose Fund			
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	8, 486, 430	0	ol	0	1.00
2.00	Temporary investments	0	0	o	0	2. 00
3.00	Notes recei vabl e	0	0	o	0	3. 00
4.00	Accounts receivable	19, 178, 444	0	0	0	4. 00
5.00	Other receivable	84, 332	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
7. 00 8. 00	Inventory Prepaid expenses	978, 747	0	0	0	
9. 00	Other current assets	770,747			0	
10. 00	Due from other funds	0	0	o	0	
11. 00	Total current assets (sum of lines 1-10)	28, 727, 953	0	О	0	11. 00
	FIXED ASSETS					
12. 00	Land	0	0		0	12. 00
13.00	Land improvements	0	0		0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	9, 446, 043	0	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-1, 649, 672			0	16.00
17. 00	Leasehold improvements	3, 337, 901	ĺ		0	17. 00
18. 00	Accumul ated depreciation	-707, 605	0	O	0	18. 00
19. 00	Fi xed equipment	157, 301	0	o	0	19. 00
20. 00	Accumulated depreciation	-64, 144	0	0	0	20. 00
21. 00	Automobiles and trucks	19, 893	0	0	0	21. 00
22. 00	Accumulated depreciation	-19, 893	0	0	0	22. 00
23. 00 24. 00	Maj or movable equipment	18, 341, 910 -8, 243, 260		0	0	23. 00
25. 00	Accumulated depreciation Minor equipment depreciable	-0, 243, 200 0		0	0	25.00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0	0	Ö	0	27. 00
28. 00	Accumulated depreciation	0	0	O	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	20, 618, 474	0	0	0	30.00
21 00	OTHER ASSETS Investments	199	0	ol	0	31.00
31. 00 32. 00	Deposits on Leases	199			0	31.00
33. 00	Due from owners/officers	0		-	0	33.00
34. 00	Other assets	57, 655, 038	· -		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	57, 655, 237	0	О	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	107, 001, 664	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	0.050.405				
37. 00	Accounts payable	3, 853, 695	0	0	0	37. 00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	0	1 0	0	0	38.00
40. 00	Notes and Loans payable (short term)	7, 580, 000		0	0	40.00
41. 00	Deferred income	0	ĺ	o	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	O	0	43. 00
44. 00	Other current liabilities	1, 213, 784		0	0	1
45. 00		12, 647, 479	0	0	0	45. 00
46. 00	LONG TERM LIABILITIES	1 0	0		0	46. 00
47. 00	Mortgage payable Notes payable	16, 016, 650	· -		0	
48. 00	Unsecured Loans	10,010,030			0	1
49. 00	Other long term liabilities	16, 584, 261	0	Ö	0	
50.00	Total long term liabilities (sum of lines 46 thru 49	32, 600, 911	0	O	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	45, 248, 390	0	0	0	51.00
	CAPITAL ACCOUNTS	1 /4 750 07/	Г			
52.00	General fund balance	61, 753, 274				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted					55.00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	61, 753, 274			0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	107, 001, 664	0	0	0	60.00
	[59]	I	I	ı I		I

0

0

0

0

5.00

6.00

7. 00

8.00

9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 TRANSFERS 13.00 ROUNDING 14.00 15.00 16.00 17.00 Total deductions (sum of lines 12-17)	66, 300, 000 2 0 0	0 128, 053, 276 66, 300, 002	0 0 0 0 0	0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
19.00 Fund balance at end of period per balance		61, 753, 274		0		19. 00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	Erradimierre i aria					
	6.00	7. 00	8. 00			
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 TRANSFERS 13.00 ROUNDING 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0 0	0 0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

5.00

6.00

7.00

8.00

Health Financial Systems ORTHOPAEDI C HOSPT. AT PARKVI EW In Lieu of Form CMS-2552-10 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150167 Peri od: Worksheet G-2 From 01/01/2014 Parts I & II Date/Time Prepared: 12/31/2014 5/29/2015 7:34 am Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 6, 916, 000 6, 916, 000 1.00 2.00 SUBPROVIDER - IPF SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 5.00 Swing bed - SNF 0 0 Swing bed - NF 6.00 0 SKILLED NURSING FACILITY 7.00 8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 6, 916, 000 6, 916, 000 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT BURN INTENSIVE CARE UNIT 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of lines 16, 00 0 0 11 - 15) 17.00 6, 916, 000 Total inpatient routine care services (sum of lines 10 and 16) 6, 916, 000 18.00 Ancillary services 176, 078, 871 9, 739, 142 185, 818, 013

Heal th	Financial Systems ORTHOPAEDIC HOSPT. AT	F PARKVI EW	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150167	Peri od:	Worksheet G-3	
			From 01/01/2014	D-+- /T: D	
			To 12/31/2014	Date/Time Pre 5/29/2015 7:3	
				372772013 7.3	4 (1111
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		341, 901, 076	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			198, 139, 044	•
3.00	Net patient revenues (line 1 minus line 2)			143, 762, 032	ı
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	()		65, 257, 243	1
5.00	Net income from service to patients (line 3 minus line 4)			78, 504, 789	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			-17, 537	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	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 tha	n patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	1
18. 00	Revenue from sale of medical records and abstracts			0	1 .0.00
19. 00				0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING REV			567, 566	24. 00

550, 029 25. 00 79, 054, 818 26. 00

-5, 999 27. 00 -5, 999 28. 00 79, 060, 817 29. 00

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

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

27.00 GAIN OF SALE OF ASSET

Heal th	Financial Systems ORTHOPAEDIC HOSPT	AT PARKVIEW	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 150167	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prep 5/29/2015 7:34	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			657, 497	1. 00
1. 00	Model 4 BPCI Capital DRG other than outlier			037, 497	1. 00
2. 00	Capital DRG outlier payments			9, 190	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00				15. 02	3. 00
4.00				0.00	4. 00
5.00	· · · · · · · · · · · · · · · · · · ·			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01)	0	6. 00
7. 00					7. 00
8.00	Percentage of Medicaid patient days to total days (see instruc	ctions)		0.00	8. 00
9.00	Sum of lines 7 and 8			0. 00	
10.00	Allowable disproportionate share percentage (see instructions)			0. 00 0	
11. 00					11. 00
12. 00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2	2.01, 6 and 11)		666, 687	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 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00
5.00	Total impatrent program capital cost (fine 3 x fine 4)			U	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 circumstance	es (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0. 00 0	4. 00 5. 00
6.00	Percentage adjustment for extraordinary circumstances (see ins	structions)		0. 00	
7.00	Adjustment to capital minimum payment level for extraordinary		line 6)	0.00	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)	circuiistances (iiile 2 x	. Title 0)	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as applic	cable)		0	9. 00
10.00	Current year comparison of capital minimum payment level to ca		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)			0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pay	yments (line 10 plus lin	ie 11)	0	12. 00
	Current year exception payment (if line 12 is positive, enter			Ö	13. 00
13.00				Ö	14. 00
13. 00 14. 00	Carryover of accumulated capital minimum payment level over ca (if line 12 is negative, enter the amount on this line)				
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	15. 00
14. 00 15. 00	(if line 12 is negative, enter the amount on this line)			0	15. 00 16. 00