Used the Einsensial Systems OPTUDAEDLC US			of Form CMC DEED 10
Health Financial Systems ORTHOPAEDIC HC This report is required by law (42 USC 1395q; 42 CFR 413.20(b)).	SPT. AT PARKVIEW		L OF FORM APPROVED
payments made since the beginning of the cost reporting period b			OMB NO. 0938-0050
paymentes made since the beginning of the cost reporting period t		000 1070g).	EXPIRES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICAT	ION Provider CCN: 15-0167	Peri od:	Worksheet S
AND SETTLEMENT SUMMARY		From 01/01/2016	Parts I-III
		To 12/31/2016	Date/Time Prepared:
PART I - COST REPORT STATUS			6/28/2017 9:43 am
Provider 1. [X] Electronically filed cost report		Date: 6/28/20	17 Time: 9:43 am
use only 2. [] Manually submitted cost report		54(0) 0/ 20/ 20	
3. 0 ] If this is an amended report enter the nu	ber of times the provider r	esubmitted this co	ost report
4. [ F ] Medicare Utilization. Enter "F" for full (	r"L" for low.		·
Contractor 5. [1] Cost Report Status 6. Date Received:		IPR Date:	
use only (1) As Submitted 7. Contractor No.	11. (	Contractor's Vendo	or Code: 4
(2) Settled without Audit 8. [N]Initial Report	for this Provider CCN 12.		lumn i is 4: Enter les reopened = 0-9.
(3) Settled with Audit 9. [N]FINAL Report (4) Reopened			les reopened = 0-9.
(4) Reopened (5) Amended			
PART II - CERTIFICATION			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED			-
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LA			
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY	OF A KICKBACK OR WERE OTHERV	/ISE ILLEGAL, CRIM	IINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PR	OVI DER(S)		
I HEREBY CERTIFY that I have read the above certification electronically filed or manually submitted cost report a			
Expenses prepared by ORTHOPAEDIC HOSPT. AT PARKVIEW (15-			
01/01/2016 and ending 12/31/2016 and to the best of my l			
correct, complete and prepared from the books and record			
instructions, except as noted. I further certify that I			
provision of health care services, and that the services			
compliance with such laws and regulations.			
(Si	gned)		
	Officer or Admini	strator of Provid	er(s)
	Title		
	Data		
	Date		
	Title XVIII		

	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX		
		1.00	2.00	3.00	4.00	5.00		
	PART III - SETTLEMENT SUMMARY							
1.00	Hospi tal	0	1, 553	26, 086	0	0	1.00	
2.00	Subprovider - IPF	0	0	0		0	2.00	
3.00	Subprovider – IRF	0	0	0		0	3.00	
5.00	Swing bed - SNF	0	0	0		0	5.00	
6.00	Swing bed - NF	0				0	6.00	
200.00	Total	0	1, 553	26, 086	0	0	200.00	

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

	AL AND HOSPITAL HEALTH CARE COMPLEX I			Provi d	er CCN: í	5-0167	Period: From 01/01 To 12/31	/2016	Workshe Part I Date/Ti 6/28/20	me Pre	pared
	1.00		00		3.00			4.00			
	Hospital and Hospital Health Care Co Street: 11119 PARKVIEW PLAZA DRIVE	PO Box:									1.
	City: FORT WAYNE	State: I	N	7in Cod	- 46845 -	1705 Coun	ty: ALLEN				2.
<u> </u>		Component Na		CCN	CBSA	Provi dei	1	Pavme	ent Syste	em (P.	2.
				lumber	Number	Туре	Certified		, 0, or		
								V	XVIII	XIX	1
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen	t Identification:				-		-			
)	Hospi tal	ORTHOPAEDIC HOSP	T. AT   1	150167	23060	1	11/08/200	7 N	P	Р	3.
_		PARKVI EW									
	Subprovider - IPF										4.
	Subprovider - IRF Subprovider - (Other)										5. 6.
	Swing Beds - SNF Swing Beds - NF										7. 8.
	Hospital-Based SNF										9.
00	Hospi tal -Based NF										10.
00	Hospi tal-Based OLTC										111.
	Hospital-Based HHA										12.
	Separately Certified ASC										13.
	Hospi tal -Based Hospi ce										14.
	Hospital -Based Health Clinic - RHC										15.
	Hospital-Based Health Clinic - FQHC					1					16.
	Hospital-Based (CMHC) I										17.
	Renal Dialysis										18.
00	Other										19.
							From		To:		
							1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2016	12/31/	2016	20.
00	Type of Control (see instructions)						4				21.
20	Inpatient PPS Information	ourrently ready		nto for	dionnon	antionata	e N		N		1 22
00	Does this facility qualify and is it share hospital adjustment, in accord								IN		22.
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				2.100(0)		e				
	Did this hospital receive interim un				s cost r	eportina	N		Ν		22.
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)										
	Is this a newly merged hospital that						N		Ν		22.
	determined at cost report settlement	•	,			2	es				
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for	no, for the porti	on of the	cost r	eporting	period c	n				
	or after October 1.		c								
	Did this hospital receive a geograph								N		22.
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column :										
	cost reporting period occurring on o										
	hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,			ouncou		dance in t					
	Which method is used to determine Me			d/or 25	bel ow?	In column	n	3	Ν		23.
	1, enter 1 if date of admission, 2 i	f census days, or	- 3 if dat	e of di	scharge.	ls the					
	method of identifying the days in th										
	used in the prior cost reporting per	od? In column 2									
			In-State			ut-of		Medi ca		ther	
			Medi cai d			State		HMO da	J	i cai d	
			paid days	1 3		di cai d	Medicaid		d	ays	
				unp da		id days	el i gi bl e unpai d				
			1.00	2.		3.00	4.00	5.00	6	. 00	1
00	If this provider is an IPPS hospital	enter the		0	0	3.00	4.00	3.00	0		24.
	in-state Medicaid paid days in colum			-	Ĭ		S S			0	
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
	If this provider is an IRF, enter th			o	0	0	0		0		25.
	Medicaid paid days in column 1, the					-	-				
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column										
				1		1					1
	Medicaid eligible unpaid days in col	umn 4, Medicaid									

	Financial Systems ORTHOPAED		T. AT PARKVIEW Provider CC		Peri od:		u of For Workshe		
					From 01/01/ To 12/31/				
					Urban/Rur	al S	6/28/20 Date of		2 am
26.00	Enter your standard geographic classification (not wa	ne) st:	atus at the her	inning of the	1.00	1	2. (	00	26.00
	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	rural. ge) sta "2" fo	atus at the end or rural. If ap	of the cost		1			27.00
85. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. 00
					Begi nni		Endi		
36.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0	00	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	·			0			37.00
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				Ν				37.01
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (		-
39.00	Does this facility qualify for the inpatient hospital 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 uiremer	er in column 1 nts in accordan	"Y" for yes ce with 42			N		39.00
10.00	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.	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40.00
						V 1.00	XVIII 2.00	XI X 3.00	
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for (	li sproporti onat	e share in ac	cordance	N	N	N	45.00
6. 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
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
6. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. l1 ing period?	<sup>-</sup> column 1 Enter "Y"	N			57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer complet	nt for physicia te Wkst. D-5.		as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				2	N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"						Direct	t GME	
		1.00	2.00	3.00	4.00		5. (		
01.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
01. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. 00	0. (	00				61.01
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0. (	bo				61. 02
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0. (	bo				61.03
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.0	bo				61.04
o1. 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. (	00				61.05

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH C/			PT. AT PARKVIEW		eriod:	u of Form CMS-2 Worksheet S-2	
					com 01/01/2016 0 12/31/2016	Part I	pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
<ol> <li>Enter the amount of ACA used for cap relief and/ care or general surgery.</li> </ol>	or FTEs that are nonprimar	y	0.00	0.00			61.
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
specialty, if any, and t for each new program. (s column 1, the program na program code, enter in c	5, specify each new program he number of FTE residents ee instructions) Enter in me, enter in column 2, the olumn 3, the IME FTE er in column 4, direct GME				0.00	0.00	61.
I.20 Of the FTEs in line 61.0 program specialty, if an residents for each expan instructions) Enter in c enter in column 2, the p	y, and the number of FTE ded program. (see olumn 1, the program name, rogram code, enter in colum d count and enter in colum				0. 00	0. 00	61.
						1.00	-
	the Health Resources and				od for which	0.00	42
	residents that your hospita RSA PCRE funding (see inst		d in this cost	reporting peri	od for which	0.00	02.
during in this cost repo	residents that rotated from rting period of HRSA THC p Claim Residents in Nonprov	rogram. (	<u>see instructior</u>		your hospital	0.00	62.
3.00 Has your facility traine	d residents in nonprovider o in column 1. If yes, com	settings	during this co		eriod? Enter	N	63.
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te 1.00	2.00	3.00	-
	Base Year FTE Residents in						
4.00 Enter in column 1, if li in the base year period, resident FTEs attributab settings. Enter in colu resident FTEs that train	after July 1, 2009 and be ne 63 is yes, or your faci the number of unweighted i le to rotations occurring mn 2 the number of unweigh ed in your hospital. Enter (column 1 + column 2)). (so	lity trai non-prima in all no ted non-p in colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00			
	Program Name	Pr	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00		2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if I is yes, or your facility trained residents in the year period, the program associated with primary FTEs for each primary ca program in which you tra residents. Enter in colu the program code, enter column 3, the number of unweighted primary care residents attributable t rotations occurring in a non-provider settings. E column 4, the number of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column divided by (column 3 + c	base name care re ined mn 2, in FTE o II nter in ed in column 3			0.00	0.00	0. 000000	

	Financial Systems		IC HOSPT. AT PARKVIEW			eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2016 o 12/31/2016		pared:
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovider Setting	1.00 sEffective fo	2.00 pr cost reporti	3.00 ng periods	
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. Ty care resident the ratio of	0.00	0. 00	0. 000000	66. 00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00		1.00	2.00	3.00	4.00	5.00	(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67.00
					1.0	0 2.00 3.00	
	Inpatient Psychiatric Facility P					0 2.00 3.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME teaching 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	program in the es or "N" for r in a new teach es or "N" for r	most no. (see ni ng no.	0	70. 00 71. 00
75 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRE) or does it c	ontain an IRF	N		75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the "Y" for yes or in accordance column 2 is Y,	most "N" for with 42	0	76.00
						1.00	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N N	80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excluded unit) under			N	85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			(1)(B)(iv)(II)?	'Enter "Y"	Ν	87.00
					V	XI X	
	Title V and XIX Services				1.00	2.00	
90.00	Does this facility have title V		hospital services? E	nter "Y" for	N	Y	90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th			Ν	N	91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy					N	92.00
	instructions) Enter "Y" for yes Does this facility operate an IC	or"N" for no in the	applicable column.	, ,	N	N	93.00
	"Y" for yes or "N" for no in the Does title V or XIX reduce capit	applicable column.			N	N	93.00 94.00
	applicable column.				I		

	T. AT PARKVIEW		1	n Lieu	l of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti		
			V		6/28/20 XI 2		<u>2 am</u>
			1.00		2.0		
<ul> <li>95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.</li> </ul>	blicable column s or "N" for no	n. Din the	0. 00 N		0. C N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable column	ו.	0.00		0. C	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	,	nod of paymen	t				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr 25 and the pr	ructions) lf rogram is cos					107.00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				h	Deenin		108.00
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respir 4. 0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Ν						109.00
					1.0	0	-
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)fo	r	N		110.00
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	If column 2 i nt for long ter	s "E", enter rm care (incl	in column udes	N		0	115.00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur	for yes or "N' rance? Enter "N	' for no. Y" for yes or	"N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy	is	1			118.00
		Premiums	Losse	s	Insura	ance	
		1.00	2.00		3. C		-
118.01 List amounts of malpractice premiums and paid losses:		251, 4	50	0		(	0118.01
			1.00		2.0	0	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 119.00 DO NOT USE THIS LINE			N				118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in	າcolumn 1,່"Y'	' for yes or			Ν		120. 00
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2. "Y" for yes or "N" for no.							
Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	nts? (see instr	ructions)	Y				121.00
Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th	nts? (see instr antable devices Enter "Y" for	ructions) s charged to yes or "N"					121. 00 122. 00
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> </ul>	nts? (see instr antable devices Enter "Y" for ne Worksheet A	ructions) s charged to yes or "N" line number	Y				122.00
<ul> <li>Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> </ul>	nts? (see instr antable devices Enter "Y" for ne Worksheet A pr yes and "N"	fuctions) s charged to yes or "N" line number for no. If	Y N				
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All Providers						454000	- 1 4 0 0
0.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. If	<sup>r</sup> yes, and home o	office costs	5	Y	15H032	140. 0
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7. 00 Was there a change in the statist 8. 00 Was there a change in the order o 9. 00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ical basis? Enter "Y" for f allocation? Enter "Y" fo ied cost finding method? E ider that qualifies for ar "N" for no for each compor ampus hospital that has or Name 0	r yes or "N" for Ther "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the applic and Part B. N N N N N Sess in diffe	erent CBS	3.00 the Iowe <u>CFR §413</u> N N N N N SAS? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N T.00 T.00 FTE/Campus 5.00	148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
7.00       Was there a change in the statist         8.00       Was there a change in the order o         9.00       Was there a change to the simplif         Does this facility contain a prov or charges? Enter "Y" for yes or         5.00       Hospital         6.00       Subprovider - IPF         7.00       Subprovider - IRF         8.00       SUBPROVIDER         9.00       SNF         0.00       HOME HEALTH AGENCY         1.00       CMHC         6.00       If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? E ider that qualifies for ar "N" for no for each compor ampus hospital that has or Name 0 T) incentive in the Americ	r yes or "N" for Ther "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the applic and Part B. N N N N N Sees in diffe	erent CBS	3.00 the Iowe <u>CFR §413</u> N N N N N SAS? CBSA	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N S TE/Campus 5.00 0.1	148. 00 149. 00 155. 00 156. 00 157. 00 159. 00 160. 00 161. 00 165. 00 165. 00 00 166. 00
7. 00 Was there a change in the statist 8. 00 Was there a change in the order o 9. 00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7. 00 Is this provider a meaningful use	ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? E ider that qualifies for ar "N" for no for each compor ampus hospital that has or Name 0 1 1 1 incentive in the Americ r under §1886(n)? Enter "	r yes or "N" for The "Y" for yes Part A 1.00 n exemption from nent for Part A a N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the applic and Part B. N N N N N Sees in diffe	erent CBS	3.00 the Iowe <u>CFR §413</u> N N N N N SAS? <u>CBSA</u> 4.00	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N S T.00 FTE/Campus 5.00 0.1	148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0 165. 0
7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	ical basis? Enter "Y" for f allocation? Enter "Y" for ied cost finding method? E ider that qualifies for ar "N" for no for each compor ampus hospital that has or Name 0 Name 0 T) incentive in the Americ r under §1886(n)? Enter " 05 is "Y") and is a meanir HIT assets (see instructio not a meaningful user, doe	can Recovery and Y" for yes or "N" for Part A 1.00 n exemption from N N N N N N N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the applic and Part B. N N N N N N Sess in diffe State Zi 2.00 Rei nvestme V" for no. 167 is "Y") qualify for	Ti ati on of (See 42 erent CBS p Code 3.00 nt Act o, enter c a hards	3.00 the lowe CFR §413 N N N N N SAS? CBSA 4.00 the	N N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N S TE/Campus 5.00 0.1	148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 160. 0 00 166. 0 00 166. 0

Health Financial Systems ORTHOP	PAEDIC HOSPT. AT PARKVIEW	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		eriod: 	Worksheet S-2 Part I	
	Тс			
		Begi nni ng	Endi ng	
		1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date an period respectively (mm/dd/yyyy)	nd ending date for the reporting	10/01/2015	09/30/2016	170.00
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any da section 1876 Medicare cost plans reported on Wkst. "Y" for yes and "N" for no in column 1. If column 1876 Medicare days in column 2. (see instructions)	. S-3, Pt. I, line 2, col. 6? Enter 1 is yes, enter the number of section	Ν	0	171.00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0167	Peri od: From 01/01/2016 To 12/31/2016		epared:
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	er all dates in t	he	_
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.00
	reporting period: IT yes, enter the date of the change in c	01 01111 2. (366	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	-
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	N			4.00
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		IN IN			5.0
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	_
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	5 N		6.00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved		al education	Ν		9.00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V /N	11.0
					Y/N 1.00	
	Bad Debts					
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12.0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		*		N	14.0
5.00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> t A	ructions. Par	N t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
5.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/28/2017	Y	04/28/2017	17. 0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19. 0

Heal th	Fi nanci al	Systems

## ORTHOPAEDI C HOSPT. AT PARKVI EW

In Lieu of Form CMS-2552-10

Health Financial Systems ORTHOPAEDIC HOS HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider (	CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Date/Time Pr 6/28/2017 9:	2 epared:
		iption	Y/N	Y/N	
20.00 lf line 1/ on 17 is yes where divite noted a DCAD		0	1.00 N	3.00 N	20.00
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's	N		Ν		21.00
records? If yes, see instructions.					_
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)			
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, see				N	22.00
23.00 Have changes occurred in the Medicare depreciation expense	due to apprai	sals made dur	ing the cost	N	23.00
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered	od into during	this cost ro	porting poriod?		24.00
If yes, see instructions	eu mito uurmy	this cost re	porting periou?		24.00
25.00 Have there been new capitalized leases entered into during	the cost repo	rting period?	lf yes, see		25.00
i nstructi ons.		0.1	5		
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th	he cost report	ing period? I	f yes, see		26.00
instructions.				N	07.00
27.00 Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? it	yes, submit	N	27.00
Interest Expense					
28.00 Were new loans, mortgage agreements or letters of credit er	ntered into du	ring the cost	reporting	N	28.00
period? If yes, see instructions.		-			
29.00 Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29.00
treated as a funded depreciation account? If yes, see instr 30.00 Has existing debt been replaced prior to its scheduled matu		dab+2 If yoo		N	20.00
30.00 Has existing debt been replaced prior to its scheduled matu instructions.	unity with new	debt? IT yes	, see	IN	30.00
31.00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see	Ν	31.00
instructions.		3			
Purchased Servi ces					
32.00 Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32.00
arrangements with suppliers of services? If yes, see instru 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		na to competi	tive bidding? If		33.00
no, see instructions.		ng to competi	tive broaring: II		33.00
Provi der-Based Physi ci ans					
34.00 Are services furnished at the provider facility under an ar	rrangement wit	h provider-ba	sed physi ci ans?	N	34.00
If yes, see instructions.					
35.00 If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35.00
physicians during the cost reporting period? If yes, see in	nstructions.	-	Y/N	Date	-
			1.00	2.00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report?			Y		36.00
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		37.00
If yes, see instructions.	fi oo di fforont	from that of	N		20.00
38.00 If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			Ν		38.00
39.00 If line 36 is yes, did the provider render services to othe			. N		39.00
see instructions.			,		
40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.00
instructions.					
	1	00	2	00	_
Cost Report Preparer Contact Information		. 00	2.	00	
41.00 Enter the first name, last name and the title/position	ERIC		NI CKESON		41.00
held by the cost report preparer in columns 1, 2, and 3,	1				
respecti vel y.					1
42.00 Enter the employer/company name of the cost report	PARKVI EW HEAL	TH SYSTEM, IN	C.		42.00
preparer.	(240) 272 040	۷			12 00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8400	U	ERI C. NI CKESON@	PARKVIEW. CUM	43.00
$\Gamma$ oper propurer in corumns range, respectively.	1		1		11

Heal th	Financial Systems ORTHOPAEDIC H	IOSP <sup>-</sup>	T. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0167		eri od:	Worksheet S-	2
				To	rom 01/01/2016 p 12/31/2016		epared: 4 <u>2 am</u>
		L					
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	D	DI RECTOR, REI MBURSEMENT				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems OI AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RTHOPAEDIC HOSP	Provider C	CN: 15-0167	Peri od:	u of Form CMS-2 Worksheet S-3	
103111				SN. 13 0107	From 01/01/2016 To 12/31/2016	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	37	13, 5	42 0.00	0	1.00
3.00 4.00	HMO I PF Subprovi der HMO I RF Subprovi der						3.00
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 beds) (see instructions)		37	13, 5	42 0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						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, 5	42 0.00		14.00
15.00	CAH visits					0	15.0
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER - IRF						17.0
18.00 19.00							18.0 19.0
	SKILLED NURSING FACILITY						
20.00	NURSING FACILITY						20.0 21.0
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.0
22.00	AMBULATORY SURGICAL CENTER (D. P. )	115.00					22.0
24.00	HOSPICE	115.00					24.0
24.10	HOSPICE (non-distinct part)	30, 00					24.1
25.00	CMHC - CMHC	30.00					25.0
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
27.00	Total (sum of lines 14-26)	07.00	37				27.0
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room		-				32.01
	outpatient days (see instructions) LTCH non-covered days						33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC			riod: om 01/01/2016 12/31/2016	Worksheet S-3 Part I Date/Time Pre 6/28/2017 9:4	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	-	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	843	256	5, 49	94			1.00
2.00	HMO and other (see instructions)	1, 337	0					2.00
3.00	HMO I PF Subprovi der	0	0					3.00
4.00	HMO I RF Subprovi der	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	843	256	5, 49	94			7.00
3.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9.0
0.00	BURN INTENSIVE CARE UNIT							10.0
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)	843	256	5, 49		0.00	206.10	
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.0
7.00	SUBPROVIDER - IRF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY							19.0
0.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY					0.00	0.00	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P. )					0.00	0.00	
4.00	HOSPICE	0	0		~			24.0
24.10	HOSPICE (non-distinct part)	0	0		0			24.1
5.00	CMHC - CMHC							25.0
26.00	RURAL HEALTH CLINIC	0	0		~	0.00	0.00	26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0. 00 0. 00	0.00	26.2
7.00 8.00	Total (sum of lines 14-26)		20	27		0.00	206.10	
	Observation Bed Days	0	28	30	66			28.0
9.00	Ambulance Trips Employee discount days (see instruction)	0		1.	48			29.0 30.0
1.00	Employee discount days (see fistraction) Employee discount days - IRF			12	48 0			30.0
31.00 32.00	1 3	0	0		0			31.0
	Labor & delivery days (see instructions)	0	0		0			
32.01	Total ancillary labor & delivery room				U			32. 0 <sup>.</sup>
	outpatient days (see instructions) LTCH non-covered days	0						33.0

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 6/28/2017 9:42	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	84		2, 685	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF			62	24 0 0 0		2.00 3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6.00 7.00 8.00
9.00 10.00 11.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						9.00 10.00 11.00
12.00 13.00 14.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0.00	0	84	13 29	2, 685	12.00 13.00 14.00
15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00		0-		2,000	15. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
23.00 24.00 24.10 25.00 26.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	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	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

,	AL WAGE INDEX INFORMATION			Provider CC		eriod: rom 01/01/2016 o 12/31/2016		pare
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							-
	Total salaries (see	200.00	18, 270, 685	5, 955, 383	24, 226, 068	885, 631. 00	27.35	1.
0	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2
	A		0	0		0.00	0.00	
D	Non-physician anesthetist Part		0	0	0	0.00	0.00	3
0	Physician-Part A -		0	0	0	0.00	0.00	4
1	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4
o	Physician and Non		0	0	0	0.00		
0	Physician-Part B		0	0	0	0.00	0.00	6
0	Non-physician-Part B for hospital-based RHC and FQHC services		0	0		0.00	0.00	
0	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
1	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7
0	programs) Home office and/or related		0	5, 202, 051	5, 202, 051	173, 694. 00	29.95	8
	organization personnel	44.00	0					
0 00	SNF Excluded area salaries (see	44.00	0 6, 651, 952	0 986, 419	0 7, 638, 371	0. 00 313, 825. 00		
	instructions)		-,,	,				
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		0	0	0	0.00	0.00	1 1 1
	Care		0	0	0	0.00	0.00	
00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12
00	services Contract Labor: Physician-Part		0	о	0	0.00	0.00	13
	A - Administrative		0	0		0.00	0.00	
00	Home office and/or related orgainzation salaries and		0	5, 202, 051	5, 202, 051	173, 694. 00	29.95	14
	wage-rel ated costs							
	Home office salaries Related organization salaries		0	0	0	0. 00 0. 00		
-	Home office: Physician Part A		0	0	0	0.00		
	- Administrative		0			0.00		
	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
	WAGE-RELATED COSTS						1	
00	Wage-related costs (core) (see instructions)		3, 428, 175	0	3, 428, 175			17
00	Wage-related costs (other)		0	0	0			18
00	(see instructions) Excluded areas		2, 462, 838	0	2, 462, 838			19
	Non-physician anesthetist Part		0	0	0			20
00	A Non-physician anesthetist Part		Ω	0	∩			21
	В		0	0				
00	Physician Part A - Administrative		0	0	0			22
	Physician Part A - Teaching		0	0	0			22
	Physician Part B Wage-related costs (RHC/FQHC)		0	0				23
	Interns & residents (in an		0	0	0			24
50	approved program) Home office wage-related		1, 590, 724	~	1, 590, 724			25
	Related orgainzation		1, 370, 724	0	1, 390, 724			25
	wage-related Home office: Physician Part A		0	0	0			25
	- Administrative - wage-related							
53	Home office & Contract		0	0	0			25
	Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIE	S			L	l	1	
	Employee Benefits Department	4.00	2, 736, 510	-2, 736, 510	0	0.00	0.00	1 ~

Heal th	Financial Systems	OF	THOPAEDIC HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part II Date/Time Pre 6/28/2017 9:4	pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0		0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	133, 779	299, 018	432, 79	7 17, 855.00	24.24	30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	204, 181	43, 138	247, 31	9 17, 859. 00	13.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0. 00	33.00
34.00	Dietary	10. 00	0	258, 167	258, 16	7 6, 602. 00	39. 10	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	0		0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0		0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	28, 862	28, 86	2 732.00	39.43	39.00
40.00	Pharmacy	15.00	0	16, 363			39.15	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0.00	0.00	41.00
42.00	Soci al Servi ce	17.00	185, 804	0	185, 80	4 6, 698. 00	27.74	42.00
43.00	Other General Service	18.00	0	0		0.00		43.00

Heal th	Financial Systems	OI	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
	-	1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1				
1.00	Net salaries (see		18, 270, 685	753, 332	19, 024, 01	7 711, 937. 00	26. 72	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		6, 651, 952	986, 419	7, 638, 37	1 313, 825. 00	24.34	2.00
3.00	Subtotal salaries (line 1		11, 618, 733	-233, 087	11, 385, 64	6 398, 112. 00	28.60	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		0	5, 202, 051	5, 202, 05	1 173, 694. 00	29.95	4.00
5.00	Subtotal wage-related costs (see inst.)		5, 018, 899	0	5, 018, 89	9 0.00	44.08	5.00
6.00	Total (sum of lines 3 thru 5)		16, 637, 632	4, 968, 964	21, 606, 59	6 571, 806. 00	37.79	6,00
7.00	Total overhead cost (see		3, 955, 658					
	instructions)			I	l	I	I	

Heal th	Financial Systems ORTHOPAEDIC HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016		pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			0	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			331, 566	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			568, 400	
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	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			76, 845	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			3, 327, 638	
8.01	Health Insurance (Self Funded without a Third Party Administr			0	
8.02	Health Insurance (Self Funded with a Third Party Administrate	or)		0	
8.03	Heal th Insurance (Purchased)			0	0.00
9.00	Prescription Drug Plan			0	
10.00	Dental, Hearing and Vision Plan			0	
11.00	Life Insurance (If employee is owner or beneficiary)			32, 556	1
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			87, 806	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	y)		0	
15.00	'Workers' Compensation Insurance			24, 067	
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)				-
17 00	TAXES FICA-Employers Portion Only			1 220 470	17 00
				1, 339, 478	
18.00	Medicare Taxes - Employers Portion Only Unemployment Insurance			0	
19.00				0	
20.00	State or Federal Unemployment Taxes OTHER			0	20.00
21 00	Executive Deferred Compensation (Other Than Retirement Cost F	Departed on Lines 1 three	igh 1 abovia (caa	54, 631	21.00
21.00	instructions))	Reported on Thes T through	igit 4 above. (See	54, 051	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			48, 027	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			5, 891, 014	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Heal th	Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVI EW	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0167	Peri od:	Worksheet S-3	
			From 01/01/2016 To 12/31/2016		narod
			10 12/31/2010	6/28/2017 9: 4	
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Iden				
1.00	Total facility's contract labor and benefi	t cost	0	5, 891, 014	
2.00	Hospi tal		0	5, 891, 014	
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	
6.00	Swing Beds - SNF		0	0	
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC		0	0	1.2.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17.00	Renal Dialysis			1	17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems ORTHOR	PAEDIC HOSPT. AT P.	ARKVI EW		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA			N: 15-0167	Peri od:	Worksheet S-1	
					From 01/01/2016		norod.
					To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
						0/20/2011 /.4	
						1.00	
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 20	02 column 3 divide	ed by lin	e 202 column	18)	0. 183368	1.00
	Medicaid (see instructions for each line)					1	
2.00	Net revenue from Medicaid					603, 985	
3.00	Did you receive DSH or supplemental payments from				-	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH of			rom Medicai	1?	N N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental	payments from Me	eaicaia			-345, 729	5.00
6.00	Medicaid charges					9, 589, 968	6.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medi	anid program (lin		o our of Liv	and E. if	1, 758, 493	
8.00	<pre>&lt; zero then enter zero)</pre>	card program (TT	ne / minu	IS SUIT OF IT	ies z and s; TT	1, 500, 237	8.00
	Children's Health Insurance Program (CHIP) (see i	nstructions for e	each line	)			
9.00	Net revenue from stand-al one CHIP			)		0	9.00
10.00						0	
	Stand-alone CHIP cost (line 1 times line 10)					0	
	Difference between net revenue and costs for star	nd-alone CHIP (lir	ne 11 min	us line 9: i	f < zero then	0	
	enter zero)					-	
	Other state or local government indigent care pro	gram (see instruc	ctions fo	r each line)		•	1
13.00	Net revenue from state or local indigent care pro	ogram (Not include	ed on lin	es 2, 5 or 9	))	4, 062, 860	13.00
14.00	Charges for patients covered under state or local	indigent care pr	rogram (N	ot included	in lines 6 or	25, 084, 653	14.00
	10)						
15.00	State or local indigent care program cost (line 1					4, 599, 723	
16.00	Difference between net revenue and costs for stat	te or local indige	ent care	program (lin	ne 15 minus line	536, 863	16.00
	13; if < zero then enter zero)	```					
17 00	Uncompensated care (see instructions for each lin Private grants, donations, or endowment income re		ing chari	ty cara		0	17.00
18.00	0						
19.00	Total unreimbursed cost for Medicaid, CHIP and s				(sum of lines	2, 037, 100	
19.00	8, 12 and 16)		nurgent c	are programs	S (Sull OF THES	2,037,100	19.00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
				1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see	e instructions)		100, 42	602, 268	702, 689	20.00
21.00				18, 4	110, 437	128, 851	21.00
22.00	Partial payment by patients approved for charity	care			0 3, 736		
23.00	Cost of charity care (line 21 minus line 22)			18, 4	106, 701	125, 115	23.00
						1.00	
24.00	Does the amount in line 20 column 2 include charge			d a length o	of stay limit	N	24.00
25 00	imposed on patients covered by Medicaid or other			anomio Longi	h of atom limit		25 00
25.00	If line 24 is "yes," charges for patient days be Total bad debt expense for the entire hospital co			gram s reng	n of stay limit	0 2, 587, 437	
26.00							
27.00	Medicare bad debts for the entire hospital complete Non-Medicare and non-reimbursable Medicare bad de			Lino 27)		28, 148 2, 559, 289	
28.00				,	28)	469, 292	
30.00			se (inne		20)	594, 407	
	Total unreimbursed and uncompensated care cost (I		30)			2, 631, 507	
51.00	retar an ernou sed and ancompensated care cost (i		23)			2,001,007	1 3 1. 00

	ORTHOPAEDI C HOSPT				u of Form CMS-2	2552-1
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C		Period: From 01/01/2016	Worksheet A	
				To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati		
·			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	1	0 477 004	0 477 00	1 204 0/4	1 272 2/0	1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT		2, 477, 224				
2.00 00200 CAP REL COSTS-MVBLE EQUIP 3.00 00300 OTHER CAP REL COSTS		0		0 907, 479 0 0		
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 736, 510	5, 373, 645	8, 110, 15	-	8, 110, 155	
5. 00 00500 ADMINI STRATI VE & GENERAL	695, 384	15, 618, 551				
7.00 00700 OPERATION OF PLANT	133, 779	1, 358, 535			1, 491, 937	
8.00 00800 LAUNDRY & LINEN SERVICE	133,777	1, 330, 333	1, 472, 51	0 0	0	
9. 00 00900 HOUSEKEEPI NG	204, 181	224, 388	428, 56	о С	428, 569	
10. 00 01000 DI ETARY	201,101	258, 167			258, 167	
11. 00 01100 CAFETERIA	0	0		0 0	0	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13.00 01300 NURSING ADMINI STRATION	0	0		0 0	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	28, 862	28, 86	02 0	28, 862	14.00
15. 00 01500 PHARMACY	0	16, 363			16, 363	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00 01700 SOCIAL SERVICE	185, 804	15, 904	201, 70	0 8	201, 708	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	19.00
20.00 02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	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	2, 172, 179	267, 617	2, 439, 79	-40, 323	2, 399, 473	30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 451, 095	26, 185, 127			7, 882, 941	
53. 00 05300 ANESTHESI OLOGY	0	0		0 499, 381	499, 381	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	348, 776			344, 909	
58. 00 05800 MRI	318, 248	0	318, 24		318, 248	
	0	445, 710			445, 710	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	25, 538		0 0	25, 538 0	
65. 00 06500 RESPIRATORY THERAPY	0	76, 587			76, 587	
66. 00 06600 PHYSI CAL THERAPY	659, 604	28, 532			688, 136	
69. 00 06900 ELECTROCARDI OLOGY	007,004	1, 401			1, 401	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 401		0 3, 066, 034		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 19, 230, 705		
73. 00 07300 DRUGS CHARGED TO PATIENTS	61, 949	1, 599, 173	1, 661, 12		1, 661, 122	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	.,	0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS					10 105 700	1115 00
	2, 634, 556	7, 193, 679		5 297, 485		
SPECIAL PURPOSE COST CENTERS	2, 634, 556 14, 253, 289	7, 193, 679 61, 543, 779				
SPECIAL PURPOSE COST CENTERS 115.00 AMBULATORY SURGICAL CENTER (D. P. ) 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	14, 253, 289	61, 543, 779	75, 797, 06	0	75, 797, 068	118.00
SPECIAL PURPOSE COST CENTERS           115.00         AMBULATORY SURGICAL CENTER (D. P. )           118.00         SUBTOTALS (SUM OF LINES 1-117)			75, 797, 06	08 0	75, 797, 068 5, 685, 644	118. 00 194. 00

ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN	: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Pr 6/28/2017 9:	
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		- <b>L</b> .	0/20/2017 7.	
GENERAL SERVICE COST CENTERS	6.00	7.00				-
. 00 00100 CAP REL COSTS-BLDG & FIXT	0	1, 272, 260				1.0
	0					
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-					2.
8.00 00300 OTHER CAP REL COSTS	0	-				3.
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-263, 396					4.
00500 ADMI NI STRATI VE & GENERAL	2, 590, 441	18, 906, 104				5.
2.00 00700 OPERATION OF PLANT	0					7.
8.00 00800 LAUNDRY & LINEN SERVICE	0	-				8.
0. 00 00900 HOUSEKEEPI NG	0	428, 569				9.
0. 00 01000 DI ETARY	0	258, 167				10.
1. 00 01100 CAFETERI A	0	0				11.
2.00 01200 MAINTENANCE OF PERSONNEL	0	0				12.
3. 00 01300 NURSING ADMINISTRATION	0	0				13.
4.00 01400 CENTRAL SERVICES & SUPPLY	0	28, 862				14.
5. 00 01500 PHARMACY	0	16, 363				15.
6.00 01600 MEDI CAL RECORDS & LI BRARY	0	0				16.
7. 00 01700 SOCIAL SERVICE	0	201, 708				17.
9. 00 01900 NONPHYSICIAN ANESTHETISTS	0	201,700				19.
20. 00 02000 NURSI NG SCHOOL	0	0				20.
1.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	-				20.
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.
INPATIENT ROUTINE SERVICE COST CENTERS	0	2 200 472				- 20
0. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS	0	2, 399, 473				
	0	7 002 041				
0. 00 05000 OPERATING ROOM						50.
3.00 05300 ANESTHESI OLOGY	0					53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.
8.00 05800 MRI	0	318, 248				58.
0. 00 06000 LABORATORY	0					60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0					62.
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.
5. 00 06500 RESPI RATORY THERAPY	0	76, 587				65.
6. 00 06600 PHYSI CAL THERAPY	0	688, 136				66.
9. 00 06900 ELECTROCARDI OLOGY	0	1, 401				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 066, 034				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	19, 230, 705				72.
3.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 661, 122				73.
6. 97 07697 CARDI AC REHABILI TATI ON	0	0				76.
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0	o				76.
6. 99 07699 LI THOTRI PSY	0					76.
OUTPATIENT SERVICE COST CENTERS		-1				
0. 00 09000 CLINIC	0	0				90.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
SPECIAL PURPOSE COST CENTERS		I				- 72.
	150 700	10.070 450				111
15. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	153, 732					115.
18.00 SUBTOTALS (SUM OF LINES 1-117)	2, 480, 777	78, 277, 845				118.
NONREI MBURSABLE COST CENTERS						
94. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	70, 631					194.
00.00 TOTAL (SUM OF LINES 118-199)	2, 551, 408	84, 034, 120				200.

CLASSI F	nancial Systems FICATIONS		RTHOPAEDI C HOSP	Provider CCN: 1	5-0167	Peri od:	u of Form C Worksheet	
						From 01/01/2016 To 12/31/2016	Date/Time	Prepare
		Increases					6/28/2017	9:42 an
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
	- BUILDING DEPRECIATON							
	AP REL COSTS-MVBLE EQUIP	2.00	0	907, 479				1
	MBULATORY SURGICAL CENTER	115.00	0	297, 485				2
	<u>D.P.)</u>	+	— — — <sub>0</sub>	1,204,964				
-	- MED AND IV SUPPLIES		0	1, 204, 904				
	EDI CAL SUPPLI ES CHARGED TO	71.00	0	22, 296, 739				1
	ATI ENT	, 1. 00	Ŭ	22,270,707				
00		0.00	o	0				2
00		0.00	0	0				3
0			0	22, 296, 739				
	- TELEPHONE EXPENSE							
	DMINISTRATIVE & GENERAL	5.00	0	1, 728				1
00	+	0.00	0	0				2
0	- BENEFITS ALLOCATION		0	1, 728				
	MPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 736, 510				1
			0	2,736,510				
F	- HOME OFFICE	I		2,700,010				
	DMI NI STRATI VE & GENERAL	5.00	4, 212, 853	0				1
DO AN	MBULATORY SURGICAL CENTER	115.00	814, 017	0				2
([	D. P. )							
	THER NONREI MBURSABLE COST	194.00	175, 182	0				3
	<u>ENTERS</u>	+						
0	- PURCHASED SERVICES		5, 202, 052	0				
	DMI NI STRATI VE & GENERAL	5.00	759, 465	0				1
	PERATION OF PLANT	7.00	299, 018	0				2
	OUSEKEEPING	9.00	43, 138	0				3
	I ETARY	10.00	258, 167	0				4
DO CE	ENTRAL SERVICES & SUPPLY	14.00	28, 862	0				5
00 PH	HARMACY	15.00	16, 363	0				6
	DULTS & PEDIATRICS	30.00	17, 281	0				7
	PERATING ROOM	50.00	958, 450	0				8
	ADI OLOGY-DI AGNOSTI C	54.00	85, 628	0				9
	ABORATORY	60.00	445, 710	0				10
	ESPI RATORY THERAPY HYSI CAL THERAPY	65.00 66.00	76, 587 180	0				11
	RUGS CHARGED TO PATIENTS	73.00	503, 772	0				12
			3, 492, 621					
	- IMPLANTS		5, 172, 521	<u> </u>				
	MPL. DEV. CHARGED TO	72.00	0	19, 230, 705				1
PA	ATI ENTS							
0			0	19, 230, 705				
	- ANESTHESI A		T					
00 <u>AN</u>	NESTHESI OLOGY	<u>53.00</u>	0	499, 381				1
0			0	499, 381				
	- ASC BENEFITS MBULATORY SURGICAL CENTER	115 00	0	2 700				1
	D. P. )	115.00	U	2, 780				1
0		- — — +		2,780				
-	rand Total: Increases		8, 694, 673	45, 972, 807				500

Heal th	Financial Systems	OF	RTHOPAEDI C HOSPT	. AT PARKVIEV	V	In Lie	u of Form CMS-2	552-10
	SIFICATIONS			Provider (	CCN: 15-0167	Peri od:	Worksheet A-6	
						From 01/01/2016 To 12/31/2016	Data /Tima Dran	orod.
						10 12/31/2016	Date/Time Prep 6/28/2017 9:42	areu: am
		Decreases						
	Cost Center	Line #	Salary	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, 204, 964	ļ	9		1.00
2.00		0.00	0		)	0		2.00
	0		0	1, 204, 964	ļ			
	B - MED AND IV SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	40, 323		0		1.00
2.00	OPERATING ROOM	50.00	0	22, 252, 549		0		2.00
3.00	RADI OLOGY-DI AGNOSTIC	<u>54.00</u>		<u>3, 867</u>		30		3.00
	C - TELEPHONE EXPENSE		U	22, 296, 739	1			
1.00	OPERATION OF PLANT	7.00	0	377	r	0		1.00
2.00	OPERATING ROOM	50.00	0	1, 351		0		2.00
2.00			— — — <del>o</del>	1, 728				2.00
	D - BENEFITS ALLOCATION		<u> </u>	1,720	, 			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2, 736, 510	C	)	0		1.00
	0		2, 736, 510	0		7		
	F - HOME OFFICE	I						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 212, 853	3	0		1.00
2.00	AMBULATORY SURGICAL CENTER	115.00	0	814, 017	r	0		2.00
	(D. P. )							
3.00	OTHER NONREI MBURSABLE COST	194.00	0	175, 182	2	0		3.00
	CENTERS							
	0		0	5, 202, 052	2			
	H - PURCHASED SERVICES	5 00		750 4/5				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	759, 465		0		1.00
2.00	OPERATION OF PLANT	7.00	0	299, 018		0		2.00
3.00 4.00	HOUSEKEEPI NG DI ETARY	9.00	0	43, 138		0		3.00 4.00
4.00 5.00	CENTRAL SERVICES & SUPPLY	10. 00 14. 00	0	258, 167 28, 862		0		4.00 5.00
5.00 6.00	PHARMACY	14.00	0	16, 363		0		5.00 6.00
7.00	ADULTS & PEDIATRICS	30.00	0	17, 281		0		7.00
8.00	OPERATING ROOM	50.00	0	958, 450		0		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	85, 628		0		9.00
10.00	LABORATORY	60.00	0	445, 710		0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	76, 587		0		11.00
12.00	PHYSI CAL THERAPY	66.00	0	180		0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	503, 772		0		13.00
	0		0	3, 492, 621		1		
	I - IMPLANTS	· · ·						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	19, 230, 705		0		1.00
	PATI ENT							
	0		0	19, 230, 705				
	J – ANESTHESIA					-1		
1.00	OPERATING_ROOM	50.00	0	499, 381		0		1.00
			0	499, 381	L			
1 00	K - ASC BENEFITS	445 00	0.700		1	0		1 00
1.00	AMBULATORY SURGICAL CENTER	115.00	2, 780	C		0		1.00
	( <u>D.</u> P. )	+			<u> </u>	-		
500 00	Grand Total: Decreases		2, 739, 290	51, 928, 190	, )	-	r	500.00
000.00		I	2, , 5 , 2 , 0	01, 720, 170	.i	1	1	

Heal th	Financial Systems 0	RTHOPAEDI C HOSF	PT AT PARKVIEW		1	n lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/ To 12/31/	/2016	Worksheet A-7 Part I	
				Acqui si ti on				
		Begi nni ng Bal ances	Purchases	Donati on	Total		Disposals and Retirements	
		1.00	2.00	3.00	4.00		5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		_				
1.00 2.00	Land Land Improvements	0	0 0		0 0	0 0	0	1.00 2.00
3.00	Buildings and Fixtures	9, 446, 043	0		0	0	0	3.00
4.00	Building Improvements	3, 997, 913	817, 295		0 81	7, 295	34, 775	4.00
5.00	Fixed Equipment	8, 786, 262	0		0	0	0	5.00
6.00	Movable Equipment	11, 041, 661	1, 610, 506		0 1,610	0, 506	754, 072	6.00
7.00	HIT designated Assets	2, 998, 371	305, 438		0 305	5, 438	0	7.00
8.00	Subtotal (sum of lines 1-7)	36, 270, 250	2, 733, 239		0 2,733	3, 239	788, 847	8.00
9.00	Reconciling Items	1, 053, 968	-480, 679		0 -480	0, 679	0	9.00
10.00	Total (line 8 minus line 9)	35, 216, 282	3, 213, 918		0 3, 213	3, 918	788, 847	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	9, 446, 043	672, 131					3.00
4.00	Building Improvements	4, 780, 433	125, 978					4.00
5.00	Fixed Equipment	8, 786, 262	44, 171					5.00
6.00	Movable Equipment	11, 898, 095	2, 964, 866					6.00
7.00	HIT designated Assets	3, 303, 809	0					7.00
8.00	Subtotal (sum of lines 1-7)	38, 214, 642	3, 807, 146					8.00
9.00	Reconciling Items	573, 289	0					9.00
10.00	Total (line 8 minus line 9)	37, 641, 353	3, 807, 146					10.00

Heal th	Financial Systems 0	ORTHOPAEDIC HOSPT. AT PARKVIEW			In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0167	Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		nared
					10 12/01/2010	6/28/2017 9:4	2 am
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 477, 224	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 477, 224	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 477, 224				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 477, 224				3.00
			•				-

Health Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 Fo 12/31/2016	Worksheet A-7 Part III Date/Time Prep 6/28/2017 9:42	
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	23, 012, 738	0	23, 012, 73		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	11, 898, 095				0	2.00
3.00 Total (sum of lines 1-2)	34, 910, 833				0	3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	0		1, 272, 260	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	907, 479	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(	2, 179, 739	0	3.00
			JMMARY OF CAPI			
Cost Center Description		Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 CAP REL COSTS-BLDG & FIXT				0	1 272 240	1.00
2.00 CAP REL COSTS-BEDG & FIXT	0				1, 272, 260 907, 479	2.00
3.00 Total (sum of lines 1-2)	0				2, 179, 739	2.00
5.00 [TOTAL (Sum OF TITLES T-2)	1 0	1 0	1		2, 179, 739	3.00

nancial Systems ORTHOP
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## AEDIC HOSPT. AT PARKVIEW

DJUSTMENTS	ncial Systems TO EXPENSES			PT. AT PARKVIEW Provider CCN: 15-0167	Peri od:	u of Form CMS- Worksheet A-8	
					From 01/01/2016 To 12/31/2016		
				Expense Classification of	n Worksheet A	6/28/2017 9:4	2 am
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00 Inves	stment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	) 1.
COSTS	S-BLDG & FIXT (chapter 2)						
	stment income - CAP REL S-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
	stment income – other oter 2)		0		0.00	C	) 3
00 Trade	e, quantity, and time		0		0.00	C	4
00 Refur	ounts (chapter 8) nds and rebates of		0		0.00	C	5
exper 00 Renta	nses (chapter 8) al of provider space by		0		0.00	C	6
suppl	iers (chapter 8)		0				
	phone services (pay ions excluded) (chapter		0		0.00	O	7
00 Telev	vision and radio service		0		0.00	C	8 (
00 Parki	oter 21) ing lot (chapter 21)		0		0.00	0	
	der-based physician stment	A-8-2	0			0	10
. 00   Sal e	of scrap, waste, etc.		0		0.00	C	11
. 00 Relat	oter 23) ted organization	A-8-1	2, 506, 796			C	12
	sactions (chapter 10) dry and linen service		0		0.00	C	13
	teria-employees and guests al of quarters to employee		0		0.00	0	
and o	others		0				
	of medical and surgical lies to other than		0		0.00	O	16
patie .00 Sale	ents of drugs to other than		0		0.00	0	) 17
patie .00 Sale	ents of medical records and		0		0.00	C	) 18
absti	racts ng school (tuition, fees,		0		0.00	C	
books	s, etc.)		0			-	
	ing machines ne from imposition of		0		0.00		
inter	rest, finance or penalty ges (chapter 21)						
.00 Inter	rest expense on Medicare		0		0.00	C	22
	payments and borrowings to y Medicare overpayments						
	stment for respiratory apy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
limit	tation (chapter 14)				(/ 22		
thera	stment for physical apy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24
	tation (chapter 14) zation review –		0	*** Cost Center Deleted **	* 114.00		25
physi	cians' compensation oter 21)		Ŭ				
.00 Depre	eciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	C	26
	S-BLDG & FIXT eciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	O	27
	S-MVBLE EQUIP physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28
. 00 Physi	cians' assistant		0		0.00		29
thera	stment for occupational apy costs in excess of	A-8-3	0	*** Cost Center Deleted **	* 67.00		30
	tation (chapter 14) ice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
	ructions) stment for speech	A-8-3	0	*** Cost Center Deleted **	* 68.00		31
patho	ology costs in excess of		0	Sost contor bereted	00.00		
. 00   CAH H	tation (chapter 14) HIT Adjustment for		0		0.00	0	32
	eciation and Interest R OPERATING REVENUE	В	_22 721	ADMI NI STRATI VE & GENERAL	5.00	C	33
	INSURANCE OFFSET	A		EMPLOYEE BENEFITS DEPARTME			35

Health Financial Systems	PT. AT PARKVI EW	eu of Form CMS-2552-10				
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0167	Period: From 01/01/2016	Worksheet A-8	
				To 12/31/2016		
			Expense Classification of	n Worksheet A		
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
36.00 NON ALLOWABLE LOBBY EXPENSE	A	-3, 990	ADMI NI STRATI VE & GENERAL	5.00	0	36.00
37.00 NET UPL ADD BACK	В	345, 729	ADMI NI STRATI VE & GENERAL	5.00	0	37.00
50.00 TOTAL (sum of lines 1 thru 49)		2, 551, 408				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.

Heal th	Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-2					
	TATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND		ME Provider CCN: 15-0167	Period:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	9, 400, 472	7, 118, 039	1.00
2.00	115.00	AMBULATORY SURGICAL CENTER (	HOME OFFICE COST REPORT	1, 816, 380	1, 662, 648	2.00
3.00	194.00	OTHER NONREIMBURSABLE COST C	HOME OFFICE COST REPORT	390, 897	320, 266	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			11,607,749	9, 100, 953	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

110.5	110 נ	been posted to worksheet A,	corumns r anu/or z, the amount	it allowable si		or this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
		B INTERPRIATIONSHIP TO PELAT	TED OPCANIZATION(S) AND/OP HO		·		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

1 of mout			
6.00	В	0.00 PARKVI EW HEALTH SYSTEM, INC 60.00	6.00
7.00	В	0.00 NORTHEAST ORTHOPAEDIC 40.00	7.00
		HOSPITAL INVE	
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

C. Provider has financial interest in corporation, partnership, or other organization.

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

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

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

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RI	ELATED ORGANIZATIONS AND HOME Provider CCN: 15-0167	Period: Worksheet A-8-1 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 6/28/2017 9:42 am

			072072011 7.	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	2, 282, 433	0		1.00
2.00	153, 732	0		2.00
3.00	70, 631	0		3.00
4.00	0	0		4.00
5.00	2, 506, 796			5.00

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

110	as not	been posted to worksheet A,		the amount			tin s part.	
		Related Organization(s)						
		and/or Home Office						
		Type of Business						
		51						
		6, 00						
-			· · · · · · · · · · · · · · · · · · ·					
		B. INTERRELATIONSHIP TO RELATIONSHIP	TED_ORGANIZATION(S)	AND/OR HOME	OFFICE:			

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

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

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

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

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

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

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

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

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

Heal th	n Financial Systems (	ORTHOPAEDI C HOSF	PT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre	epared:
				ATED COSTS		6/28/2017 9:4	
			CAPITAL REL	LATED CUSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7)					
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	1 070 0/0	1 070 0/0				1
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 272, 260	1, 272, 260				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	907, 479		907, 47			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 846, 759	0		0 7, 846, 759		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	18, 906, 104	293, 934	36, 09			
7.00	00700 OPERATION OF PLANT	1, 491, 937	0	56, 74	9 140, 182	1, 688, 868	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	
9.00	00900 HOUSEKEEPI NG	428, 569	0		0 80, 106	508, 675	9.00
10.00	01000 DI ETARY	258, 167	0	4	9 83, 620	341, 836	10.00
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	1	0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 862	0		0 9, 348	38, 210	14.00
15.00		16, 363	0		0 5, 300	21, 663	1
16.00		0	0		0 0	0	
17.00		201, 708	0		0 60, 181	261, 889	
19.00		201,700	0		0 00,101	0	1
20.00		0	0			0	
20.00		0	0		0 0	0	
21.00		0	0		0 0	0	
22.00		0	0		0 0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	U U	0		0 0	0	23.00
30.00		2, 399, 473	351, 207	65, 49	709, 160	2 525 222	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	2, 399, 473	331, 207	00,49	<sup>1</sup> 5 709, 100	3, 525, 333	30.00
F0 00		7 002 041	E02 742	201 71	E 1 7EO 10E	10 540 524	1 50 00
50.00		7,882,941	583, 743			10, 540, 534	
53.00		499, 381	0		0 0 07 705	499, 381	
54.00		344, 909	0		0 27,735	372, 644	
58.00		318, 248	24, 521	161, 62		607, 476	1
60.00		445, 710	0		0 144, 364	590, 074	
62.00		25, 538	0		0 0	25, 538	
62.30		0	0		0 0	0	
65.00		76, 587	0		0 24, 806	101, 393	
66.00		688, 136	18, 855	70	213, 702	921, 394	
69.00		1, 401	0		0 0	1, 401	
71.00		3, 066, 034	0		0 0	3, 066, 034	71.00
72.00		19, 230, 705	0		0 0	19, 230, 705	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 661, 122	0	51, 24	4 183, 235	1, 895, 601	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	1	0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS					• •	
90.00	09000 CLI NI C	0	0		0 0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS						1
115.00	0 11500 AMBULATORY SURGICAL CENTER (D.P.)	10, 279, 452	0	156, 29	1, 116, 082	11, 551, 831	1115.00
118.00		78, 277, 845					
	NONREI MBURSABLE COST CENTERS		.,,		-,,,,,,		
194.00	007950 OTHER NONREI MBURSABLE COST CENTERS	5, 756, 275	0	57, 51	0 1, 357, 963	7, 171, 748	194.00
200.00		2, , 00, 2,0	0		.,,	0	200.00
201.00	5		Ω		0 0	0	201.00
202.00		84,034,120	1, 272, 260	907, 47	-		
202.00		0.,001,120	., 2, 2, 200	, , , , ,	.,,	0.,00.,120	

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 6/28/2017 9:4	pared: 2 am
	Cost Center Description	ADMI NI STRATI VE <u>&amp; GENERAL</u> 5. 00	OPERATION OF PLANT 7.00	LAUNDRY &	HOUSEKEEPI NG E 9.00	DI ETARY 10. 00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	21,071,892					5.00
			2 254 000				
7.00	00700 OPERATION OF PLANT	565, 222	2, 254, 090		0		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	170, 241	0		0 678, 916		9.00
10.00		114, 404	0		0 0	456, 240	•
11.00		0	0		0 0	0	11.00
12.00		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	12, 788	0		0 0	0	14.00
15.00	01500 PHARMACY	7, 250	0		0 0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
17.00		87, 648	0		0 0	0	17.00
19.00		0//0/0	0		0 0	0	19.00
20.00		0	0		0 0	0	20.00
20.00 21.00		0	0		0 0	0	21.00
21.00		0	0		0 0	0	22.00
22.00		0	0		0 0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	23.00
30.00		1, 179, 841	809, 189	1	0 243, 722	454 240	200.00
30.00	ANCI LLARY SERVICE COST CENTERS	1, 179, 041	009, 109		0 243,722	456, 240	30.00
50.00		2 527 452	1 244 042		0 405, 094	0	50.00
		3, 527, 653	1, 344, 963				
53.00		167, 130	0		0 0	0	53.00
54.00		124, 715	0		0 0	0	54.00
58.00		203, 307	56, 496		0 17,016	0	58.00
60.00		197, 483	0		0 0	0	60.00
62.00		8, 547	0		0 0	0	62.00
62.30		0	0		0 0	0	62.30
65.00		33, 934	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	308, 368	43, 442		0 13, 084	0	66.00
69.00	06900 ELECTROCARDI OLOGY	469	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 026, 125	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 436, 043	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	634, 410	0		0 0	0	73.00
76.97		0	0		0 0	0	76.97
76.98		0	0		0 0	0	76.98
76.99		0	0		0 0	0	
/0. //	OUTPATIENT SERVICE COST CENTERS			1	0 0	0	, 0. , ,
90.00	i i i i i i i i i i i i i i i i i i i	0	0		0 0	0	90.00
92.00		0	0		0	0	92.00
92.00				l			92.00
115 0	SPECIAL PURPOSE COST CENTERS	2.0(/ 100		1		0	
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 866, 109	0		0 0		115.00
118.0		18, 671, 687	2, 254, 090		0 678, 916	456, 240	1118.00
	NONREI MBURSABLE COST CENTERS			1			
	0 07950 OTHER NONREIMBURSABLE COST CENTERS	2, 400, 205	0		0 0	0	194.00
200. 0							200.00
			0	1	0 0	0	1201 00
201. 0	0 Negative Cost Centers 0 TOTAL (sum lines 118-201)	21, 071, 892	0		0 0 0 678, 916	0	201.00

Heal th	Financial Systems 0	RTHOPAEDI C HOSPT	. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I	epared:
	Cost Center Description		AINTENANCE OF PERSONNEL	NURSING ADMINISTRATI(	CENTRAL ON SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	,					
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 0 0 0 0 0 0			0 0 50, 998 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28, 913 0 0 0	16. 00 17. 00
20.00	02000 NURSI NG SCHOOL	0	C		0 0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	(		0 0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	(		0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	(		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	0	(	<u>ן</u>	0 0	0	30.00
50.00	05000 OPERATING ROOM	0	(	1	0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	(		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(		0 0	0	
58.00	05800 MRI	0	C	b	0 0	0	
60.00	06000 LABORATORY	0	(		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(		0 0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0	(		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	(	2	0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	(		0 0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		0 50, 998	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(		0 50, 448	28, 913	
76.97	07697 CARDI AC REHABI LI TATI ON	0	(		0 0	20, 719	1
	07698 HYPERBARI C OXYGEN THERAPY	0	(		0 0	0	
76.99	07699 LI THOTRI PSY	0	(		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	• •		•			1
		0	(	D	0 0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(		0 0		115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)           NONREIMBURSABLE COST CENTERS	0	(		0 50, 998	28, 913	118.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	(		0 0	0	194.00
200.00							200.00
201.00		0	(		0 0		201.00
202.00	) TOTAL (sum lines 118-201)	0	(	ין	0 50, 998	28, 913	202.00

JUST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016		
	Cost Center Description	RECORDS & LI BRARY		ANESTHETI STS		Y & FRI NGES APPRV	
		16.00	17.00	19.00	20.00	21.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 ~
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 3.00							
9.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						
							10.00
	01100 CAFETERIA						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	0					15.00
	01600 MEDICAL RECORDS & LIBRARY	0	240 527				16.00
	01700 SOCI AL SERVI CE	0	349, 537				17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0		19.0
	02000 NURSI NG SCHOOL	0	0		0		20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	349, 537		0 0	0	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	0	349, 337	l	0 0	0	30.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05300 ANESTHESI OLOGY	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
	05800 MRI	0	0		0 0	0	
	06000 LABORATORY	0	0			0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			0	
	06500 RESPIRATORY THERAPY	0	0			0	
	06600 PHYSI CAL THERAPY	0	0			0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	
	07697 CARDI AC REHABI LI TATI ON	0	0			0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
	07699 LI THOTRI PSY	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	0	0		0		/0. /
	09000 CLINIC	0	0		0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						90.00
/2.00	SPECIAL PURPOSE COST CENTERS		I	I			72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0 0	0	115.00
115.00 118.00					0 0		118.00
	NONREIMBURSABLE COST CENTERS	0	349, 537		0 0	0	1110.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0			0 0		194.00
200.00		0	0		0 0		200. 00
	TUTUSS FUUL AUTUSTINENTS	1	1	1	0 0		
200.00		0			0 0		201.00

2.00         00200         CAP. REL_COSTS-MUBLE EQUIP         2.0         4.0           4.00         00400         EMPLYTSE DEPRITISE DEPRITY         4.0           5.00         00500         ADMINISTRATIVE & GENERAL         7.0           0.00         00500         DEPRLITSE DEPRITYED         8.00           0.00         00500         DEPRLITSE DEPRITYED         9.0           0.00         00500         DEPRLITSE DEPRITYED         9.0           0.00         00500         DEPRLITSE DEPRITYED         9.0           0.00         00500         DEPRLITSE DEPRLICE         9.0           1.00         DIOSC DEPRLITSE         10.0         10.0           1.00         DIOSC DEPRLITSE         11.0         11.0           1.00         DIOSC DEPRLITSE         11.0         11.0           1.00         DIOSC DEPRLITSE DEPRLICE         11.0         11.0           1.00         DIOSC DEPRLITSE         11.0         11.0           1.00         DIOSC	Heal th Fi	inancial Systems	ORTHOPAEDIC HOSF	PT. AT PARKVLEW		In Lie	u of Form CMS-:	2552-10
Internet	COST ALL	OCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	From 01/01/2016	Part I	pared:
CENTRAL SERVICE COST CENTERS         22.00         23.00         24.00         25.00         26.00           10         00100 CAP REL COSTS-BLD & FIXT         1         1         1         1         1         00100 CAP REL COSTS-BUD & FIXT         1         1         0         1         0         1         0 <t< td=""><td></td><td>Cost Center Description</td><td>RESI DENTS SERVI CES-OTHER PRGM COSTS</td><td></td><td>Subtotal</td><td>Intern &amp; Residents Cost &amp; Post Stepdown</td><td><u>6/28/2017 9:4</u> Total</td><td></td></t<>		Cost Center Description	RESI DENTS SERVI CES-OTHER PRGM COSTS		Subtotal	Intern & Residents Cost & Post Stepdown	<u>6/28/2017 9:4</u> Total	
1.00         00100 CAP REL COSTS-BLOG & FLXT         1.00           2.00         00200 CAP REL COSTS-BUDE & FLXT         2.00           4.00         00400 EMPLOVEE BENEFITS DEPARTIMENT         5.00           5.00         00500 OPERATION OF PLANT         8.00           8.00         00400 EMPLOVEE BENEFITS DEPARTIMENT         5.00           5.00         00500 OPERATION OF PLANT         8.00           8.00         00400 DEFLARY         1.00           1.00         01000 CAP REL OSTS-BLOG & FLXT         8.00           9.00         00400 DEFLARY         1.00           1.00         01000 CAF ETERIA         1.00           1.00         01100 CAF ETERIA         1.00           1.00         01100 CAF ETERIA         1.00           1.00         01300 MRSI MK ADMINI STANTION         1.00           1.00         01300 MRSI MK SCHOL         1.00           1.00         01500 MEDI CAL, RECORDS & LI BRARY         1.00           1.00         1.00 KRSI MK SCHOL         1.00           2.00         02200 MRSI MK SCHOL         1.00           2.00         02200 MRSI MK SCHOL         1.00           2.00         01400 MRSI MK SCHOL         1.00           2.00         01400 KRSI MK SCHOL<			22.00	23.00	24.00		26.00	
2. 00 00200 CAP. REL. COSTS-WUBLE EQUIP 2 2. 0 2. 0 00500 ADMINISTRATIVE & CENERAL 5. 0 0. 00500 AMINISTRATIVE & CENERAL 5. 0 0. 001400 CENTRAL SERVICES & SUPPLY 5. 0 0. 01400 AMINISTRATIVE & CENERAL 5. 0 0. 01530 AMINISTRATIVE & CENERAL 5. 0 0. 01400 AMINISTRATIVE & CENERAL 5. 0 0. 000 AMINISTRATIVE & CENERAL 5. 000 AMINISTRATIVE & CENERAL 5. 0					1			
30. 00       00       00       6, 563, 862       0       6, 563, 862       30. 0         ANCI LLARY SERVICE COST CENTERS       0       0       15, 818, 244       0       16, 90 <td><math display="block">\begin{array}{cccccccccccccccccccccccccccccccccccc</math></td> <td>02000       CAP REL COSTS-MVBLE EQUI P         0400       EMPLOYEE BENEFI TS DEPARTMENT         0500       ADMI NI STRATI VE &amp; GENERAL         0700       OPERATI ON OF PLANT         0800       LAUNDRY &amp; LI NEN SERVI CE         0900       HOUSEKEEPI NG         1000       DI ETARY         1100       CAFETERI A         1200       MAI NTENANCE OF PERSONNEL         1300       NURSI NG ADMI NI STRATI ON         1400       CENTRAL SERVI CES &amp; SUPPLY         1500       PHARMACY         1600       MEDI CAL RECORDS &amp; LI BRARY         1700       SOCI AL SERVI CE         1900       NURSI NG SCHOOL         2100       I&amp;R SERVI CES-SALARY &amp; FRI NGES APPRV         2200       I &amp;R SERVI CES-OTHER PRGM COSTS APPRV         2300       PARAMED ED PRGM-(SPECI FY)</td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td>1.00 2.00 4.00 5.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 17.00 19.00 20.00 21.00 21.00 23.00</td>	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	02000       CAP REL COSTS-MVBLE EQUI P         0400       EMPLOYEE BENEFI TS DEPARTMENT         0500       ADMI NI STRATI VE & GENERAL         0700       OPERATI ON OF PLANT         0800       LAUNDRY & LI NEN SERVI CE         0900       HOUSEKEEPI NG         1000       DI ETARY         1100       CAFETERI A         1200       MAI NTENANCE OF PERSONNEL         1300       NURSI NG ADMI NI STRATI ON         1400       CENTRAL SERVI CES & SUPPLY         1500       PHARMACY         1600       MEDI CAL RECORDS & LI BRARY         1700       SOCI AL SERVI CE         1900       NURSI NG SCHOOL         2100       I&R SERVI CES-SALARY & FRI NGES APPRV         2200       I &R SERVI CES-OTHER PRGM COSTS APPRV         2300       PARAMED ED PRGM-(SPECI FY)	0	C				1.00 2.00 4.00 5.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 17.00 19.00 20.00 21.00 21.00 23.00
ANCI LLARY SERVICE COST CENTERS         0         0         15, 818, 244         0         15, 818, 244         0         15, 818, 244         0         15, 818, 244         0         15, 818, 244         0         0         0         0         0         0         0         15, 818, 244         0         15, 818, 244         0         0         0         666, 511         0         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 511         0         666, 510         0         0         884, 295         0         884, 295         0         884, 295         0         884, 295         0         884, 295         0         884, 295         0         884, 295         0         84, 085         0         0         62.00         0         62.00         0         62.00         0         62.00         0         0         62.00         0 <td></td> <td></td> <td></td> <td></td> <td>6 562 9</td> <td>62 0</td> <td>6 562 962</td> <td>20.00</td>					6 562 9	62 0	6 562 962	20.00
50.00       OSO00 (PRERATI ING ROOM       0       15, 818, 244       0       15, 818, 244       0       15, 818, 244       50. 0         53.00       OS300 (ANESTHESI OLOGY       0       0       666, 511       0       666, 511       0       666, 511       0       666, 511       0       666, 511       0       667, 359       0       477, 359       54. 00       0       884, 295       0       884, 295       58. 00       0       0       787, 557       0       787, 557       60. 00       0       0       787, 557       0       787, 557       60. 00       62.00       0       0       0       34. 085       0       34. 085       62.00       0       0       0       62.30       0.6250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0       0       135, 327       0       135, 327       65. 00       0       0       0       1, 286, 288       0       1, 286, 288       0       1, 286, 288       0       1, 286, 288       0       1, 286, 288       0       1, 286, 288       06. 00       0       0       1, 00       10.00       0       1, 870       0       1, 870       0       1, 286, 288       06. 00       0       0       0       0       0       0 </td <td></td> <td></td> <td><u> </u></td> <td>C.</td> <td>0, 505, 6</td> <td>52  0</td> <td>0, 505, 802</td> <td>30.00</td>			<u> </u>	C.	0, 505, 6	52  0	0, 505, 802	30.00
53.00       05300       ANESTHESI OLOGY       0       0       6666, 511       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       497, 359       0       497, 359       54.00         68.00       05800       MRI       0       0       884, 295       0       884, 295       68.04       60.00         60.00       06000       LABORATORY       0       0       787, 557       0       787, 557       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       34, 085       0       34, 085       62.00         62.30       06500 RESPI RATORY THERAPY       0       0       135, 327       0       135, 327       65.00       62.00       69.00       0       1, 286, 288       0       1, 286, 288       64.00       69.00       69.00       69.00       6000       1, 870       0       1, 870       0       1, 87, 17.0       69.00       69.00       1, 286, 288       0       1, 286, 288       64.00       71.00       0       1, 870       0       1, 870, 188, 295       71.00       71.00       71.00       71.00       71.00       25, 717, 746       0       25, 717, 746       25, 717, 746			0		15, 818, 2	44 0	15, 818, 244	50.00
58.00       05800       MRI       0       0       884,295       0       884,295       58.0         60.00       06000       LABORATORY       0       0       787,557       0       787,557       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
60.00       06000       LABORATORY       0       787, 557       0       787, 557       60.00         62.00       06200       WHOLE       BLOOD & PACKED RED BLOOD CELL       0       0       34, 085       0       34, 085       0       34, 085       0.0       <			0	C				
60.00       06000       LABORATORY       0       787, 557       0       787, 557       60.00         62.00       06200       WHOLE       BLOOD & PACKED RED BLOOD CELL       0       0       34, 085       0       34, 085       0       34, 085       0.0       <			0	C				
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       34,085       0       34,085       62.00         62.30       06250       BLODD CLOTTING FOR HEMOPHI LIACS       0       0       0       62.00         65.00       06500       RESPIRATORY THERAPY       0       0       135,327       0       135,327       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       1,286,288       0       1,286,288       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       1,870       0       1,870       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       25,717,746       025,717,746       025,717,746       025,717,746       076.92,558,924       03.07698       176.92       73.00       0 <td>60.00 06</td> <td>6000 LABORATORY</td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td></td>	60.00 06	6000 LABORATORY	0	C				
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       0       135,327       0       135,327       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       1,286,288       0       1,286,288       69.00         69.00       06900       ELECTROCARDIOLOGY       0       1,870       0       1,870       0       1,870       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       4,092,159       0       4,092,159       71.00       72.00         72.00       07200       IPL. DEV. CHARGED TO PATIENTS       0       0       2,558,924       70.00       72.00       72.00       72.00       72.00       76.97       76.97       76.97       76.97       07697       CARDIAC REHABILITATION       0       0       0       0       76.92       76.99       07699       11HOTRIPSY       0       0       0       0       76.99       0       0       0       0       76.99       0       0       0       0       76.99       0       0       0       0       0       0	62.00 06	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C				
65.00       06500       RESPIRATORY THERAPY       0       0       135, 327       0       135, 327       65.00         66.00       06600       PHYSICAL THERAPY       0       0       1, 286, 288       0       1, 092, 159       71.00       0       25, 517, 746       0       26, 576, 77, 769       72.07       0       76.99	62.30 06	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.30
69.00       06900       ELECTROCARDI OLOGY       0       1,870       0       1,870       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       4,092,159       0       4,092,159       71.00         72.00       07200       IMPL.       DEV.       CHARGED TO PATIENTS       0       0       25,717,746       0       25,717,746       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       2,558,924       0       2,558,924       0       73.00       76.97       CARDI AC REHABILI TATI ON       0       0       0       0       76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76.97       07699       LI THOTRI PSY       0       0       0       0       76.97         76.99       07699       LI THOTRI PSY       0       0       0       0       0       0       90.00         90.00       092000       DESERVATI ON BEDS (NON-DI STI NCT PART       90.00       90.00       92.00       99200       085RVATI ON BEDS (NON-DI STI NCT PART       92.00       992.00       992.00       992.00       992.01       15,417,940       15.00       15,417,940       15.01	65.00 06	6500 RESPI RATORY THERAPY	0	C	135, 3	27 0	135, 327	65.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       4, 092, 159       0       4, 092, 159       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       25, 717, 746       0       25, 717, 746       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       2, 558, 924       0       2, 558, 924       73.00         76.97       07697       CARDIAC REHABILITATION       0       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       0       76.99         76.99       07699       LI THOTRI PSY       0       0       0       0       0       0       90.00         0000       09000       CLI NI C       0       0       0       0       0       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       15, 417, 940       15, 417, 940       92.00       92.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       74, 462, 167       0       74, 462, 167       15, 417, 940       15, 417, 940	66.00 06	6600 PHYSI CAL THERAPY	0	C	1, 286, 2	88 0	1, 286, 288	66.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       25, 717, 746       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       2, 558, 924       0       2, 558, 924       73.00         76.97       07697       CARDIAC REHABILITATION       0       0       0       0       0       0       76.97         76.98       MYPERBARI C OXYGEN THERAPY       0       0       0       0       0       0       76.97         76.99       OT699       LI THOTRI PSY       0       0       0       0       0       0       76.97         0       07699       CLI NI C       0       0       0       0       0       0       0       90.00         0       09000       CLI NI C       0       0       0       0       90.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.01       92.00       92.01       92.01       92.00       92.00       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       92.01       <	69.00 06	6900 ELECTROCARDI OLOGY	0	C	1, 8	70 0	1, 870	69.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       2,558,924       0       2,558,924       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       0       0       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       0       76.97         76.99       01TPATIENT SERVICE COST CENTERS       0       0       0       0       0       0       0       76.97         09.00       09000       CLINIC       0       0       0       0       0       0       90.00         90.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       92.00       92.00         SPECI AL PURPOSE COST CENTERS       0       0       15, 417, 940       0       15, 417, 940       15, 417, 940       115.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       0       74, 462, 167       0       74, 462, 167       118.00         NONREI MBURSABLE COST CENTERS       0       0       9, 571, 953       0       9, 571, 953       194.00         200.00       Cross Foot Adj ustments       0       0       0	71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	4, 092, 1	59 0	4, 092, 159	71.00
76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76. 9         76. 98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       0       76. 9         76. 99       07699       LI THOTRI PSY       0       0       0       0       0       76. 9         000       07699       LI THOTRI PSY       0       0       0       0       0       76. 9         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       90. 00         90. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       92. 0       92. 0         SPECIAL PURPOSE COST CENTERS       115.00       11500       AMBULATORY SURGI CAL CENTER (D. P. )       0       0       15, 417, 940       0       15, 417, 940       115. 00         118. 00       SUBTOTALS (SUM OF LINES 1-117)       0       0       74, 462, 167       0       74, 462, 167       118. 00         NONREI MBURSABLE COST CENTERS       0       0       9, 571, 953       0       9, 571, 953       194. 00         200. 00       Cross Foot Adj ustments       0       0       0       0       200. 00 <td>72.00 07</td> <td>7200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0</td> <td>C</td> <td>25, 717, 7</td> <td>46 0</td> <td>25, 717, 746</td> <td>72.00</td>	72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	C	25, 717, 7	46 0	25, 717, 746	72.00
76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       76.99         76.99       07699       LI THOTRI PSY       0       0       0       0       0       76.99         000       0000       CLI NI C       0	73.00 07	7300 DRUGS CHARGED TO PATIENTS	0	C	2, 558, 9	24 0	2, 558, 924	73.00
76.99         07699         LI THOTRI PSY         0         0         0         0         76.99           OUTPATI ENT SERVICE COST CENTERS         0	76.97 07	7697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0         0         0         0         0         90.00         92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         92.00         92.00         0BSERVATI ON BEDS (NON-DI STINCT PART         0         0         92.00         <			0	C		0 0	0	76.98
90. 00       09000       CLINIC       0       0       0       0       0       90. 00         92. 00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       0       92. 00       92. 00         SPECIAL PURPOSE COST CENTERS         115.00       11500       AMBULATORY SURGICAL CENTER (D. P. )       0       0       15, 417, 940       0       15, 417, 940       115. 00         118. 00       SUBTOTALS (SUM OF LINES 1-117)       0       0       74, 462, 167       0       74, 462, 167       118. 00         NONREI MBURSABLE COST CENTERS         194. 00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       9, 571, 953       0       9, 571, 953       194. 00         200. 00       Cross Foot Adjustments       0       0       0       0       200. 00         201. 00       Negative Cost Centers       0       0       0       0       0       201. 00			0	C	)	0 0	0	76.99
92.00         09200         OBSERVATION         BEDS         (NON-DISTINCT PART         0         92.00 <td></td> <td></td> <td>-r</td> <td></td> <td></td> <td>T.</td> <td></td> <td></td>			-r			T.		
SPECIAL PURPOSE COST CENTERS           115.00         11500         AMBULATORY SURGI CAL CENTER (D. P.)         0         0         15, 417, 940         0         15, 417, 940         115.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         0         0         74, 462, 167         0         74, 462, 167         118.00           NONREI MBURSABLE COST CENTERS         0         0         9, 571, 953         0         9, 571, 953         140.00           200.00         Cross Foot Adjustments         0         0         0         0         200.00         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         0         201.00	90.00 09	9000 CLINIC	0	C		0 0	0	90.00
115.00         11500         AMBULATORY SURGI CAL CENTER (D. P.)         0         0         15, 417, 940         0         15, 417, 940         115.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         0         0         74, 462, 167         0         74, 462, 167         118.00           NONREI MBURSABLE COST CENTERS           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         9, 571, 953         194.00         200.00         200.00         0         0         0         0         0         200.00         0         0         0         0         0         0         200.00         0						0		92.00
118.00         SUBTOTALS (SUM OF LINES 1-117)         0         74,462,167         0         74,462,167         118.00           NONREI MBURSABLE COST CENTERS         0         0         9,571,953         0         9,571,953         194.00         200.00         Cross Foot Adjustments         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         0         0         0         0         200.00         201.00         0         0         0         0         0         201.00         0         0         0         201.00         0         0         201.00         0         201.00         0         0         0         201.00         0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201								
NONREI MBURSABLE COST CENTERS           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         9, 571, 953         0         9, 571, 953         194.00           200.00         Cross Foot Adjustments         0         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         201.00	115.0011		0	C	15, 417, 9	40 0	15, 417, 940	115.00
194.00         07950         0THER NONREI MBURSABLE COST CENTERS         0         0         9, 571, 953         0         9, 571, 953         194.00           200.00         Cross Foot Adjustments         0         0         0         0         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         201.00			0	C	74, 462, 1	67 0	74, 462, 167	118.00
200.00         Cross Foot Adjustments         0         0         0         0         0         200.00           201.00         Negative Cost Centers         0			-					
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00				C	9, 571, 9	53 0		
						0 0		
202.00   TOTAL (sum lines 118-201)   0  0  84,034,120  0  84,034,120 202.00								
	202.00	TOTAL (sum lines 118-201)	0	C	84, 034, 1	20  0	84, 034, 120	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ORTHOPAEDI C HOSF	Provider C		Period:	Worksheet B	2552-10
					From 01/01/2016 To 12/31/2016		pared:
	· · · · ·		CAPI TAL REL	ATED COSTS		6/28/2017 9:4	2 am
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs				DEFFICIENCE	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS						1.00
2.00	00200 CAP REL COSTS-MUBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	
5.00	00500 ADMI NI STRATI VE & GENERAL	0	293, 934	36, 09	4 330, 028	0	5.00
7.00	00700 OPERATION OF PLANT	0	0	56, 74	9 56, 749	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	
9.00	00900 HOUSEKEEPI NG	0	0		0 0	0	9.00
10.00	01000 DI ETARY	0	0	4	9 49	0	10.00
11.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	11.00
12.00 13.00	01300 NURSI NG ADMI NI STRATI ON	0	0			0	12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	14.00
15.00	01500 PHARMACY	0	0			0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	351, 207	65, 49	3 416, 700	0	30. 00
50.00	ANCI LLARY SERVICE COST CENTERS	0	331, 207	03,47	5 410,700	0	30.00
50.00	05000 OPERATING ROOM	0	583, 743	321, 71	5 905, 458	0	50. OC
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
58.00	05800 MRI	0	24, 521	161, 62	7 186, 148	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 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	18, 855	70	1 19, 556	0	65.00 66.00
69.00	06900 ELECTROCARDI OLOGY	0	10, 000	/0	1 19, 550	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	51, 24	4 51, 244	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76.99		0	0		0 0	0	76.99
	OUTPATIENT SERVICE COST CENTERS						
		0	0		0 0	0	
92.00					0		92.00
115 00	SPECIAL PURPOSE COST CENTERS	0	0	156, 29	7 156, 297	0	115.00
118.00		0	1, 272, 260				118.00
. 10. 00	NONREI MBURSABLE COST CENTERS	0	1, 272, 200	047,70	2, 122, 227	0	1 . 5. 60
194.00	07950 OTHER NONREL MBURSABLE COST CENTERS	0	0	57, 51	0 57, 510	0	194.00
200.00					0	Ū	200.00
201.00	Negative Cost Centers		0		0 0		201.00
202.00	TOTAL (sum lines 118-201)		1, 272, 260	907, 47			202.00

Heal th	Financial Systems	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 6/28/2017 9:4	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LI NEN SERVI C		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT						4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	330, 028					5.00
7.00	00700 OPERATION OF PLANT	8, 853	65, 602				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0,000	00,002		0		8.00
9.00	00900 HOUSEKEEPI NG	2,666	0		0 2,666		9.00
10.00	01000 DI ETARY	1, 792	0		0 0	1, 841	
11.00	01100 CAFETERI A	0	0		0 0	0	
12.00	01200 MAI NTENANCE 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	200	0		0 0	0	
15.00	01500 PHARMACY	114	0		0 0	0	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	1
17.00	01700 SOCIAL SERVICE	1, 373	0		0 0	0	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDI ATRI CS	18, 480	23, 550		0 957	1, 841	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	55, 253	39, 144		0 1, 591	0	50.00
53.00	05300 ANESTHESI OLOGY	2, 618	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 953	0		0 0	0	
58.00	05800 MRI	3, 184	1, 644		0 67	0	
60.00	06000 LABORATORY	3, 093	0		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	134	0		0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	532	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	4,830	1, 264		0 51	0	
69.00	06900 ELECTROCARDI OLOGY	/	0		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	16, 072	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	100, 788	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 937	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	
/0.99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	76.99
90.00	09000 CLINIC	0	0	1	0 0	0	90.00
90.00 92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS	0	0		0 0	0	90.00 92.00
115 00	D11500 AMBULATORY SURGICAL CENTER (D. P. )	60, 555	0		0 0	0	115.00
118.00		292, 434	65, 602		0 2,666		118.00
	NONREI MBURSABLE COST CENTERS	272,104	00, 002		2,300	1, 041	
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	37, 594	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)	330, 028	65, 602		0 2,666		202.00
							-

Heal th	Financial Systems	ORTHOPAEDI C HOSPI	. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016		pared: 2 am
	Cost Center Description	CAFETERI A M	AI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI (	CENTRAL ON SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0					10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0		0 200		14.00
15.00	01500 PHARMACY	0	0		0 0	114	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0			0	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	1
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	•
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	•
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
58.00	05800 MRI	0	0		0 0	0	58.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65.00		0	0		0 0	0	
66.00		0	0		0 0	0	66.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 200	0	72.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 200	114	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	1
76.99	07699 LI THOTRI PSY	0	0		0 0	0	
/0. //	OUTPATIENT SERVICE COST CENTERS						/0. //
90.00	09000 CLINIC	0	0		0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		-				92.00
72.00	SPECIAL PURPOSE COST CENTERS	· ·					
92.00			0		0 0	0	115.00
		0	U				
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 200	114	118.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P. )					114	118.00
115.00 118.00	11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1-117)						118.00 194.00
115.00 118.00	11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 200	0	194. 00 200. 00
115.00 118.00 194.00	11500       AMBULATORY SURGICAL CENTER (D. P. )         SUBTOTALS (SUM OF LINES 1-117)         NONREIMBURSABLE COST CENTERS         07950       OTHER NONREIMBURSABLE COST CENTERS         Cross Foot Adjustments         Negative Cost Centers	0	0		0 200	0	194.00

		DRIHOPAEDIC HOS	PT. AT PARKVIEW			u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		
						INTERNS &	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV	
		16.00	17.00	19.00	20.00	21.00	
1 00	GENERAL SERVICE COST CENTERS	1	1	1			1 1 00
1.00 2.00	00200 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
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	(	D				16.00
17.00	01700 SOCIAL SERVICE	(	1, 373				17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	(	0 0	(	)		19.00
	02000 NURSI NG SCHOOL	(	0 0		0		20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	(				0	
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	(					22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	(	0 0				23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1 272	1			1 20 00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	(	0 1, 373			L	30.00
50.00	05000 OPERATING ROOM	(	o lo				50.00
	05300 ANESTHESI OLOGY						53.00
	05400 RADI OLOGY-DI AGNOSTI C	(	ol o				54.00
	05800 MRI	(	0 0				58.00
60.00	06000 LABORATORY	(	o o				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
	06600 PHYSI CAL THERAPY	(	0 0				66.00
	06900 ELECTROCARDI OLOGY	(	0 0				69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	(	0 0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	(	0				72.00
	07300 DRUGS CHARGED TO PATIENTS		0				73.00
	07697 CARDIAC REHABILITATION		0				76.97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY		-				76.98
	OUTPATIENT SERVICE COST CENTERS	(	<u>ار</u> 0	I	<u> </u>		/0.99
	09000 CLINIC	(	0 10				90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1				92.00
00	SPECIAL PURPOSE COST CENTERS						1
115.00	11500 AMBULATORY SURGICAL CENTER (D. P. )	(	0 0				115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	(			0 0	0	118.00
	NONREI MBURSABLE COST CENTERS	-					
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0 0				194.00
200.00	Cross Foot Adjustments			0			200.00
200.00 201.00 202.00			0 0 0 1,373				201.00 202.00

	Financial Systems	ORTHOPAEDIC HOSP		CN. 15 01/7		u of Form CMS-2	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider C	UN: 15-0167	Period: From 01/01/2016	Worksheet B Part II	
					To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
		INTERNS &				0/20/2017 7.4	
		RESI DENTS					
	Cost Center Description	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	Total	
		APPRV	PRGM		& Post		
		7.11.1.1			Stepdown		
					Adjustments		
	GENERAL SERVICE COST CENTERS	22.00	23.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSI CI AN ANESTHETI STS						19.00
	02000 NURSING SCHOOL						20.00
	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0					21.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1		1			
30.00	03000 ADULTS & PEDI ATRI CS			462, 90	01 0	462, 901	30.00
	ANCI LLARY SERVI CE COST CENTERS			1			1
	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY			1, 001, 44		1,001,446	
	05400 RADI OLOGY OLOGY			2, 6 <sup>-</sup> 1, 95		2, 618 1, 953	
	05800 MRI			191, 04		1, 933	
	06000 LABORATORY			3, 09		3, 093	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			13		134	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0 0	0	62.30
	06500 RESPI RATORY THERAPY			53		532	
	06600 PHYSI CAL THERAPY			25, 70	01 0	25, 701	
	06900 ELECTROCARDI OLOGY			1/ 0	7 0	7	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			16, 07		16, 072 100, 988	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			100, 98		61, 295	
	07697 CARDI AC REHABI LI TATI ON			01, 25	0 0	01, 295	
	07698 HYPERBARI C OXYGEN THERAPY				0 0	0	
	07699 LI THOTRI PSY				0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C				0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
115 00	SPECIAL PURPOSE COST CENTERS			216, 85	2	214 052	1115 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1-117)	0	0			216, 852 2, 084, 635	
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	0	2,004,03	0	2,004,035	110.00
	07950 OTHER NONREI MBURSABLE COST CENTERS			95, 10	04 0	95, 104	194.00
194.00	UTYOUUTER NUNKEIMDURSADLE CUST CENTERS	1					
194.00 200.00		0	0		0 0		
	Cross Foot Adjustments Negative Cost Centers	0 0	0 0 0		0 0 0 0	0	200. 00 201. 00

Health Fi	nancial Systems 0	RTHOPAEDI C HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2016	Worksheet B-1	
					o 12/31/2016		pared:
		CAPI TAL REI	LATED COSTS			6/28/2017 9:4	2 am
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
	cost center bescription		(DOLLAR VALUE)	BENEFITS	Reconciliation	& GENERAL	
			. ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FLXT 0200 CAP REL COSTS-MVBLE EQUIP	80, 837	1, 728, 154				1.00 2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 728, 154	24, 226, 068			4.00
	0500 ADMI NI STRATI VE & GENERAL	18, 676	68, 735	5, 667, 702		62, 962, 228	
	0700 OPERATION OF PLANT	0	108, 070	432, 797		1, 688, 868	
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	0	0	C 247, 319	-	0 508, 675	8.00 9.00
	1000 DI ETARY	0	93	258, 167		341, 836	
	1100 CAFETERI A	0	0	C	0	0	11.00
	200 MAINTENANCE OF PERSONNEL	0	0	C	0	0	12.00
	I 300 NURSI NG ADMI NI STRATI ON I 400 CENTRAL SERVI CES & SUPPLY		0	28, 862	0	0 38, 210	13.00 14.00
	1500 PHARMACY	0	0	16, 363		21, 663	1
	1600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	
	1700 SOCIAL SERVICE	0	0	185, 804	0	261, 889	
	1900 NONPHYSI CI AN ANESTHETI STS 2000 NURSI NG SCHOOL	0	0		0	0	19.00 20.00
	2100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21.00
	2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22.00
	2300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23.00
	IPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS	22, 315	124, 721	2, 189, 460	0	3, 525, 333	30.00
AN	ICI LLARY SERVI CE COST CENTERS			2/10//100		0, 020, 000	
	5000 OPERATING ROOM	37,090		5, 409, 545		10, 540, 534	50.00
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0	0	85, 628	0	499, 381 372, 644	53.00 54.00
	5800 MRI	1, 558	307, 794	318, 248		607, 476	
	5000 LABORATORY	0	0	445, 710		590, 074	
	5200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	25, 538	
	5250 BLOOD CLOTTING FOR HEMOPHILIACS 5500 RESPIRATORY THERAPY	0	0	76, 587	0	0 101, 393	62.30 65.00
	5600 PHYSI CAL THERAPY	1, 198	1, 335	659, 784		921, 393	66.00
69.00 06	5900 ELECTROCARDI OLOGY	0	0	C	0	1, 401	69.00
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	3, 066, 034	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0	0 97, 586	565, 721	0	19, 230, 705 1, 895, 601	1
	7697 CARDI AC REHABI LI TATI ON	0	0	505,721		1, 093, 001	1
	7698 HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
		0	0	C	0	0	76.99
	JTPATIENT SERVICE COST CENTERS	0	0	C	0	0	90.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART		Ŭ			0	92.00
	PECIAL PURPOSE COST CENTERS	T					
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0		3, 445, 793			
118.00	SUBTOTALS (SUM OF LINES 1-117) DNREIMBURSABLE COST CENTERS	80, 837	1, 618, 636	20, 033, 490	-21, 071, 892	55, 790, 480	118.00
	7950 OTHER NONREI MBURSABLE COST CENTERS	0	109, 518	4, 192, 578	0	7, 171, 748	194.00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	1 070 0/0	007 470			21 071 000	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 272, 260	907, 479	7, 846, 759		21, 071, 892	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 738585	0. 525115	0. 323897		0. 334675	203.00
204.00	Cost to be allocated (per Wkst. B,			C		330, 028	
205.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0.005242	205 00
205.00	II)			0.00000		0.003242	203.00
			. <b>·</b>				

			Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre 6/28/2017 9:43	pare
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NO (SQUARE FEET	G DI ETARY ) (MEALS SERVED)	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
00         0           00         0	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE D1900 NONPHYSICIAN ANESTHETISTS D2000 NURSING SCHOOL D2100 I&R SERVICES-SALARY & FRINGES APPRV D2200 I&R SERVICES-OTHER PRGM COSTS APPRV D2300 PARAMED ED PRGM-(SPECIFY)	62, 161 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		62, 16	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 2 4 5 7 8 9 10 11 12 13 14 15 16 17 19 20 21 22 23
- H	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	1	0 0	0	23
- E	03000 ADULTS & PEDI ATRI CS	22, 315	C	22, 31	5 23, 599	0	30
	ANCI LLARY SERVI CE COST CENTERS	37,090	C	37, 09	0 0	0	50
. 00 . 00 . 00 . 00 . 00 . 30	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	0, 0, 0, 0 0 1, 558 0 0 0			0 0 0 0		53 54 58 60 62 62
. 00 . 00 . 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	0 1, 198 0 0 0		1, 19	0 0 28 0 0 0 0 0 0 0	0 0 0 0	65 66 69 71 72
00 97 98 99	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0 0 0	73 76 76 76
00 00	DUTPATIENT SERVICE COST CENTERS D9000 CLINIC D9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0	C		0 0	0	90 92
5. 00 3. 00	11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0 62, 161	C		0 0 51 23, 599		115 118
). 00 . 00	07950 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0	C		0 0		194 200 201
2.00	Cost to be allocated (per Wkst. B, Part I)	2, 254, 090					202
8. 00 . 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	36. 262126 65, 602	0. 000000 C	10. 92189 2, 66			203 204

Heal th	Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
	LLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
	Cont Conton Description			CENTRAL	DUADMACY	6/28/2017 9:4	2 am
	Cost Center Description	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	
		(NUMBER		SUPPLY	REQUIS.)	LIBRARY	
		HOUSED)	(DI RECT NRSI NG			(TIME SPENT)	
		12.00	HRS) 13.00	REQUIS.) 14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
12.00	01200 MAINTENANCE OF PERSONNEL	C	)				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	C	0				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	0	19, 744, 21			14.00
15.00		C	0		0 10,000	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		0		0 0	0	16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		0		0 0	0	17.00 19.00
20.00	02000 NURSI NG SCHOOL	C	0		0 0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	C	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	-		0 0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	C	0		0 0	0	23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	C	0		0 0	0	30.00
50.00	ANCI LLARY SERVICE COST CENTERS		/0		<u> </u>	0	30.00
50.00	05000 OPERATI NG ROOM	C	0		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	C			0 0	0	53.00
54.00 58.00	05400 RADI OLOGY-DI AGNOSTI C 05800 MRI	C	0		0 0	0	54.00 58.00
58.00 60.00	06000 LABORATORY				0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0		0 0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0		0 0	0	62.30
65.00	06500 RESPI RATORY THERAPY	C	0		0 0	0	65.00
66.00		C	0		0 0	0	66.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0 0	0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	19, 744, 21	-	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0		0 10, 000	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	C	-		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 OUTPATI ENT SERVI CE COST CENTERS		0		<u> </u>	0	76.99
90.00	09000 CLINIC	C	0		0 0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	-			-1 -1		
	11500 AMBULATORY SURGICAL CENTER (D. P.)				0 0 2 10,000		115.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS		0	19, 744, 21	2 10,000	0	118.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	C	0		0 0	0	194.00
200.00		1				-	200.00
201.00							201.00
202.00		C	0	50, 99	8 28, 913	0	202.00
203.00	Part I)   Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 00258	3 2.891300	0.000000	203 00
203.00		0.000000	0	20			203.00
	Part II)						
	Unit cost multiplier (Wkst. B, Part	0 000000			al <u>a arriga</u>		
205.00		0. 000000	0. 000000	0. 00001	0 0. 011400	0.000000	205.00

ST AI	LLOCATION - STATISTICAL BASIS	1	Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	6/28/2017 9:4	par
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	NURSI NG SCHOO	I NTERNS &		
		(TIME SPENT)	ANESTHETI STS (ASSI GNED TI ME)	(ASSI GNED TI ME)	Y & FRI NGES APPRV (ASSI GNED TI ME)	PRGM COSTS APPRV (ASSI GNED TI ME)	
	CENEDAL SEDVICE COST CENTEDS	17.00	19.00	20.00	21.00	22.00	-
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1
	00200 CAP REL COSTS-MVBLE EQUIP						2
	00400 EMPLOYEE BENEFITS DEPARTMENT						4
0	00500 ADMINI STRATI VE & GENERAL						5
0	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPI NG						9
00	01000 DI ETARY						10
	01100 CAFETERI A						11
	01200 MAINTENANCE OF PERSONNEL						12
	01300 NURSI NG ADMI NI STRATI ON						13
	01400 CENTRAL SERVICES & SUPPLY						14
	01500 PHARMACY						15
	01600 MEDI CAL RECORDS & LI BRARY	10.000					16
	01700 SOCIAL SERVICE	10,000					17
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	C		0		19
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0		21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			0	0	
	02300 PARAMED ED PRGM-(SPECIFY)	0				0	23
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
	03000 ADULTS & PEDIATRICS	10,000	0		0 0	0	30
ĺ	ANCILLARY SERVICE COST CENTERS		·				
00	05000 OPERATING ROOM	0	C	)	0 0	0	50
	05300 ANESTHESI OLOGY	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 0	0	
	05800 MRI	0	0	)	0 0	0	
	06000 LABORATORY	0	0	0	0 0	0	60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		)	0 0	0	62
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
		0			0 0	0	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
98	07698 HYPERBARI C OXYGEN THERAPY	0	0	þ	0 0	0	76
99	07699 LI THOTRI PSY	0	C		0 0	0	76
	OUTPATIENT SERVICE COST CENTERS	F	1	r			
	09000 CLI NI C	0	C	D	0 0	0	90
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS	-		N.			
	11500 AMBULATORY SURGICAL CENTER (D. P.)	10,000	0		0 0		115
. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	10,000	C	4	0 0	0	118
	07950 OTHER NONREIMBURSABLE COST CENTERS	0		ป	0 0	0	194
. 00	Cross Foot Adjustments	0		í l	J 0		200
. 00	Negative Cost Centers						200
2.00	Cost to be allocated (per Wkst. B,	349, 537	( )		0 0		202
	Part I)	017,007			-	0	1
. 00	Unit cost multiplier (Wkst. B, Part I)	34. 953700	0. 000000	0. 00000	0. 000000	0.000000	203
1.00	Cost to be allocated (per Wkst. B,	1, 373			0 0		204
	Part II)						
	l'ait ( )						

ST ALLOCA	ncial Systems C ATION - STATISTICAL BASIS		Provider CCN: 15-0167	Peri od:	Worksheet B-1	552-1
				From 01/01/2016 To 12/31/2016	Date/Time Prepa	ared
					6/28/2017 9:42	
	Cost Center Description	PARAMED ED PRGM				
		(ASSI GNED				
		TIME)				
		23.00				
	RAL SERVICE COST CENTERS	1				1 0
	O CAP REL COSTS-BLDG & FIXT O CAP REL COSTS-MVBLE EQUIP					1.C 2.C
	O EMPLOYEE BENEFITS DEPARTMENT					4.0
	O ADMINI STRATI VE & GENERAL					5.0
	O OPERATION OF PLANT					7. C
0800 00	O LAUNDRY & LINEN SERVICE					8. C
0090 00	0 HOUSEKEEPI NG					9. C
	0 DI ETARY					10. C
	O CAFETERI A					11. C
	O MAI NTENANCE OF PERSONNEL					12.0
	O NURSI NG ADMI NI STRATI ON O CENTRAL SERVI CES & SUPPLY					13. C
	O PHARMACY					14. C
	O MEDICAL RECORDS & LIBRARY					16. C
	O SOCIAL SERVICE					17. C
	O NONPHYSICIAN ANESTHETISTS					19. C
	O NURSI NG SCHOOL					20. C
	0 I &R SERVICES-SALARY & FRINGES APPRV					21. C
	0 I&R SERVICES-OTHER PRGM COSTS APPRV					22.0
	O PARAMED ED PRGM-(SPECIFY)	0				23. C
	TI ENT ROUTI NE SERVI CE COST CENTERS	0				20.0
	LLARY SERVICE COST CENTERS	0				30. C
	O OPERATI NG ROOM	0				50. C
00 0530	O ANESTHESI OLOGY	0				53. C
	0 RADI OLOGY-DI AGNOSTI C	0				54.C
00 0580		0				58.0
	O LABORATORY	0				60.0
	O WHOLE BLOOD & PACKED RED BLOOD CELL	0				62.0
1	0 BLOOD CLOTTING FOR HEMOPHILIACS 0 RESPIRATORY THERAPY	0				62.3 65.0
	0 PHYSI CAL THERAPY	0				66. C
	0 ELECTROCARDI OLOGY	0				69.0
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0				71. C
00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0				72. C
00 0730	O DRUGS CHARGED TO PATIENTS	0				73.C
	7 CARDI AC REHABI LI TATI ON	0				76.9
	8 HYPERBARI C OXYGEN THERAPY	0				76.9
	9 LITHOTRIPSY ATIENT SERVICE COST CENTERS	0				76.9
	OCLINIC	0				90.0
	O OBSERVATION BEDS (NON-DISTINCT PART					92.0
SPEC	I AL PURPOSE COST CENTERS					
	O AMBULATORY SURGICAL CENTER (D. P.)	0				115.0
. 00	SUBTOTALS (SUM OF LINES 1-117)	0			1	118.0
	EIMBURSABLE COST CENTERS	0				101 0
. 00 0795	Cross Foot Adjustments	0				194. C 200. C
. 00	Negative Cost Centers					200. C 201. C
. 00	Cost to be allocated (per Wkst. B,	0				201. C
	Part I)				l <sup>2</sup>	
. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			2	203. C
. 00	Cost to be allocated (per Wkst. B,	0				204. C
	Part II)					
5.00	Unit cost multiplier (Wkst. B, Part	0. 000000			2	205.0

Health Financial Systems	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016		pared: 2 am
		Title	XVIII	Hospi tal	PPS	_
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	6, 563, 862		6, 563, 8	62 0	6, 563, 862	30.00
ANCI LLARY SERVI CE COST CENTERS	15 040 044	1	45.040.0		45 040 044	50.00
50. 00 05000 OPERATI NG ROOM	15, 818, 244		15, 818, 2		15, 818, 244	1
53. 00 05300 ANESTHESI OLOGY	666, 511		666, 5		666, 511	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	497, 359		497, 3		497, 359	
58. 00 05800 MRI	884, 295		884, 2		884, 295	
	787, 557		787, 5		787, 557	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	34, 085		34, 0		34, 085	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		105.0	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	135, 327		135, 3		135, 327	
66.00 06600 PHYSI CAL THERAPY	1, 286, 288		1, 286, 2		1, 286, 288	
69. 00 06900 ELECTROCARDI OLOGY	1,870		1,8		1, 870	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	4, 092, 159		4, 092, 1		4, 092, 159	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	25, 717, 746		25, 717, 7		25, 717, 746	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 558, 924		2, 558, 9	24 0	2, 558, 924	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76. 99 07699 LI THOTRI PSY	0			0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			1	0		0.00
90. 00 09000 CLINIC	0		400.0	0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	409, 960		409, 9	60	409, 960	92.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	15, 417, 940		15, 417, 9	40	15, 417, 940	1115 00
200.00 Subtotal (see instructions)	74, 872, 127					
201.00 Less Observation Beds	409,960		4, 872, 1		409, 960	
201.00 Total (see instructions)	74, 462, 167					
	/4,402,10/	1 0	/4,402,1	0/  0	/4,402,10/	1202.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 Fo 12/31/2016	Worksheet C Part I Date/Time Pre 6/28/2017 9:4	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			7 004 44			
30. 00 03000 ADULTS & PEDI ATRI CS	7, 934, 664		7, 934, 66	4		30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	80, 134, 151	67, 798, 792			0.00000	
53.00 05300 ANESTHESI OLOGY	6, 999, 437	5, 596, 282			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 273, 883	1, 496, 441			0.00000	
58.00 05800 MRI	40, 830	9, 676, 168			0.00000	
60. 00 06000 LABORATORY	1, 760, 760	288, 403			0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	130, 841	0	130, 84		0.00000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	597, 957	222, 160			0.00000	
66. 00 06600 PHYSI CAL THERAPY	4, 072, 811	71, 615			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	38, 805	0			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 398, 720	22, 916, 990			0.00000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 882, 061	18, 046, 583			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 218, 218	4, 174, 526	16, 392, 74		0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0. 000000	0.00000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0.00000	
76. 99 07699 LI THOTRI PSY	0	0		0. 000000	0. 000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0. 000000	0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	274, 427	274, 42	7 1. 493876	0.00000	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	69,034,397				115.00
200.00 Subtotal (see instructions)	206, 483, 138	199, 596, 784	406, 079, 92	2		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	206, 483, 138	199, 596, 784	406, 079, 92	2		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	OPAEDIC HOSPT. AT PARKVIEW In Lieu of For			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepar 6/28/2017 9:42 a	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	0.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 106928				0.00
53. 00 05300 ANESTHESI OLOGY	0. 052916				3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 179531				4.00
58. 00 05800 MRI	0. 091005				8.00
60. 00 06000 LABORATORY	0. 384331				0.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 260507				2.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				2.30
65. 00 06500 RESPI RATORY THERAPY	0. 165009				5.00
66. 00 06600 PHYSI CAL THERAPY	0. 310366				6.00
69. 00 06900 ELECTROCARDI OLOGY	0. 048190			6	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130674				1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 254811				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 156101				3.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				6. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				6. 98
76. 99 07699 LI THOTRI PSY	0. 000000			7	6. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				0.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 493876			9	2.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					5.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				20	2.00

Health Financial Systems	ORTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016		pared: 2 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00		5.00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 5(0,0(0		( 5(0,0	( )	( 5(0, 0(0	1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS	6, 563, 862		6, 563, 8	62 0	6, 563, 862	30.00
ANCI LLARY SERVI CE COST CENTERS	15 010 044		15 010 0	44	15 010 044	
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	15, 818, 244		15, 818, 2		15, 818, 244	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	666, 511		666, 5		666, 511	
58. 00 05800 MRI	497, 359 884, 295		497, 3 884, 2		497, 359 884, 295	
60. 00 06000 LABORATORY	787, 557		787, 5		787, 557	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	34,085		34, 0		34, 085	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	34,083		34,0	0 0	34,085	1
65. 00 06500 RESPI RATORY THERAPY	135, 327	C C	135, 3	0	135, 327	
66. 00 06600 PHYSI CAL THERAPY	1, 286, 288		1, 286, 2		1, 286, 288	
69. 00 06900 ELECTROCARDI OLOGY	1, 200, 200		1, 200, 2		1, 200, 200	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 092, 159		4, 092, 1		4, 092, 159	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	25, 717, 746		25, 717, 7		25, 717, 746	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 558, 924		2, 558, 9		2, 558, 924	
76. 97 07697 CARDI AC REHABI LI TATI ON	2,000,721		2,000,7	0 0	2,000,721	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76. 99 07699 LI THOTRI PSY	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS	-			-1 -	-	
90. 00 09000 CLINIC	0			0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	409, 960		409, 9	60	409, 960	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	15, 417, 940		15, 417, 9	40	15, 417, 940	115.00
200.00 Subtotal (see instructions)	74, 872, 127					
201.00 Less Observation Beds	409, 960		409, 9	60	409, 960	201.00
202.00 Total (see instructions)	74, 462, 167	C	74, 462, 1	67 0	74, 462, 167	202.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	-	Period: From 01/01/2016 Fo 12/31/2016	Worksheet C Part I Date/Time Pre 6/28/2017 9:4	
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 934, 664		7, 934, 66	4		30.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	80, 134, 151	67, 798, 792			0.00000	
53. 00 05300 ANESTHESI OLOGY	6, 999, 437	5, 596, 282			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 273, 883	1, 496, 441			0.00000	
58. 00 05800 MRI	40, 830	9, 676, 168			0.00000	
60. 00 06000 LABORATORY	1, 760, 760	288, 403			0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	130, 841	0	130, 84		0. 000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	597, 957	222, 160			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	4, 072, 811	71, 615			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	38, 805	0			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 398, 720	22, 916, 990	31, 315, 71		0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 882, 061	18, 046, 583	100, 928, 64	4 0. 254811	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 218, 218	4, 174, 526	16, 392, 74	4 0. 156101	0.00000	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0. 000000	0.00000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0.00000	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0.00000	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0.00000	0.00000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	274, 427	274, 42	7 1. 493876	0.00000	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	69, 034, 397	69, 034, 39	7		115.00
200.00 Subtotal (see instructions)	206, 483, 138	199, 596, 784	406, 079, 92	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	206, 483, 138	199, 596, 784	406, 079, 92	2		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepar 6/28/2017 9:42 a	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	- 1				
30. 00 03000 ADULTS & PEDI ATRI CS				30	0.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 106928				0.00
53. 00 05300 ANESTHESI OLOGY	0. 052916				3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 179531				4.00
58. 00 05800 MRI	0. 091005				8.00
60. 00 06000 LABORATORY	0. 384331				0.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 260507				2.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				2.30
65. 00 06500 RESPI RATORY THERAPY	0. 165009				5.00
66. 00 06600 PHYSI CAL THERAPY	0. 310366				6.00
69. 00 06900 ELECTROCARDI OLOGY	0. 048190			6	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130674				1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 254811				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 156101				3.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				6. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				6. 98
76. 99 07699 LI THOTRI PSY	0. 000000			7	6.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				0.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 493876			93	2.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					5.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				203	2.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R. REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2016 To 12/31/2016	6/28/2017 9:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	15, 818, 244	1, 001, 446	14, 816, 79	98 0	0	50.00
53.00 05300 ANESTHESI OLOGY	666, 511	2, 618	663, 89	93 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	497, 359	1, 953	495, 40	06 0	0	54.00
58.00 05800 MRI	884, 295	191, 043	693, 25	52 0	0	58.00
60. 00 06000 LABORATORY	787, 557	3, 093	784, 46	64 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	34, 085	134	33, 95	51 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	135, 327	532	134, 79	95 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 286, 288	25, 701	1, 260, 58	37 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	1, 870	7	1, 86	53 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,092,159	16, 072	4, 076, 08	37 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 717, 746	100, 988	25, 616, 75	58 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 558, 924	61, 295	2, 497, 62	29 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 CLINIC	0	0	1	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	409, 960	28, 912	381, 04	18 0	0	92.00
SPECIAL PURPOSE COST CENTERS	-					
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	15, 417, 940	216, 852	15, 201, 08	38 0	0	115.00
200.00 Subtotal (sum of lines 50 thru 199)	68, 308, 265	1, 650, 646			0	200.00
201.00 Less Observation Beds	409, 960	28, 912				201.00
202.00 Total (line 200 minus line 201)	67, 898, 305					202.00
			-			-

Health Financial Systems	ORTHOPAEDI C HOSF	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0167	Period: From 01/01/2016	Worksheet C Part II	
				To 12/31/2016	Date/Time Pre 6/28/2017 9:4	epared: 2 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS						-
50.00 05000 OPERATI NG ROOM	15, 818, 244					50.00
53. 00 05300 ANESTHESI OLOGY	666, 511	12, 595, 719				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	497, 359	2, 770, 324				54.00
58.00 05800 MRI	884, 295	9, 716, 998				58.00
60. 00 06000 LABORATORY	787, 557	2, 049, 163				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	34, 085	130, 841				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY THERAPY	135, 327	820, 117	0. 16500	)9		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 286, 288	4, 144, 426	0. 3103	56		66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 870	38, 805	0. 04819	90		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 092, 159	31, 315, 710	0. 1306	74		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 717, 746	100, 928, 644	0. 2548	1		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 558, 924	16, 392, 744	0. 15610	)1		73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.0000	00		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.0000	00		76.98
76. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.99
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLINIC	0	0	0.0000	00		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	409, 960	274, 427	1. 4938	76		92.00
SPECIAL PURPOSE COST CENTERS			•			
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	15, 417, 940	69,034,397	0. 22333	37		115.00
200.00 Subtotal (sum of lines 50 thru 199)	68, 308, 265	398, 145, 258				200.00
201.00 Less Observation Beds	409, 960	0				201.00
202.00 Total (line 200 minus line 201)	67, 898, 305	398, 145, 258				202.00

Health Financial Systems (	ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 2 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	1, 00	2.00	3,00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					1	
30. 00 ADULTS & PEDIATRICS	462, 901		462, 90			1
200.00 Total (lines 30-199)	462, 901		462, 90	5, 860		200.00
Cost Center Description	Inpatient Program days	Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 ADULTS & PEDIATRICS	843	66, 589				30.00
200.00 Total (lines 30-199)	843	66, 589	1			200. 00

Health Financial Systems 0	RTHOPAEDI C HOSE	PT. AT PARKVLEW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1			-		
50.00 05000 OPERATING ROOM	1,001,446					•
53. 00 05300 ANESTHESI OLOGY	2, 618					
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 953					54.00
58. 00 05800 MRI	191, 043					
60. 00 06000 LABORATORY	3, 093				1, 083	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	134	130, 841			0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	
65. 00 06500 RESPI RATORY THERAPY	532	820, 117				
66. 00 06600 PHYSI CAL THERAPY	25, 701	4, 144, 426			8, 254	
69. 00 06900 ELECTROCARDI OLOGY	7	38, 805	0.00018	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 072	31, 315, 710			1, 371	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	100, 988	100, 928, 644	0.00100	1 26, 057, 851	26, 084	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	61, 295	16, 392, 744	0.00373	9 3, 938, 157	14, 725	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	28, 912	274, 427	0. 10535	4 0	0	92.00
200.00 Total (lines 50-199)	1, 433, 794	329, 110, 861		62, 701, 853	220, 516	200.00

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT	PARKVI EW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	TS F			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
				XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	ALLI	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00		2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	0		0		0 0	0	30.00 200.00
Cost Center Description	Total Patient Days		- col . 6)	Inpatient Program Days	Pass-Through Cost (col. 7 x col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							_
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	5, 860 5, 860		0.00	84			30.00 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0167         Period: From 01/01/2016         Worksheet D From 01/01/2016         Worksheet D Pate/Time Prepared: 6/28/2017 9: 42 am           Image: Cost Center Description         Non Physician Nursing School         All ied Health         All Other Medical Education Cost         Total Cost (sum of col 1 through col.           Image: Cost Center Description         Non Physician Nursing School         All ied Health         All Other Medical Education Cost         Total Cost (sum of col 1 through col.           Image: Cost Center Description         Non Physician Nursing School         All ied Health         All Other Medical         Total Cost (sum of col 1 through col.           Image: Cost Center Description         Non Physician Nursing School         All ied Health         All Other Medical         Total Cost (sum of col 1 through col.           Image: Cost Center Description         Image: Cost Center Description         0         0         0         0           Image: Cost Center Description         Image: Cost Center Description         0         0         0         0         0           Image: Cost Center Description         Image: Cost Center Description         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< th=""><th>Health Financial Systems (</th><th>RTHOPAEDI C HOSPI</th><th>. AT PARKVIEW</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></td<>	Health Financial Systems (	RTHOPAEDI C HOSPI	. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
Intervent Goold         To         12/31/2016         Date/Time Prepared: 6/28/2017 9:42 am           Title XVIII         Hospital         PPS           Cost Center Description         Non Physician         Nursing School         Allied th         Allied th         Cost         Cost (am) of Cost (am		RVICE OTHER PASS	Provider CO	CN: 15-0167			
Cost Center Description         Non Physician Anesthetist Cost         Nursing School         All ied Health         All Other Medical         Total Cost (sum of col 1 through col. 4)         Total Cost (sum of col 1 through col. 4)           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         0         0         0         0         50.00           53.00         05300 ANESTHESI OLOGY         0         0         0         0         53.00           54.00         05400 RADI LOGY - DI AGNOSTI C         0         0         0         0         54.00           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         0         0         62.00           64.00         0600 OLABORATORY         0         0         0         0         62.00         06200 RADI LARORY THERAPY         0         0         0         62.00         66.00         62.00         66.00         66.00         65.00         65.00           64.00         0         0         0         0         0         0         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00 <t< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td></td><td>nared</td></t<>	THROUGH COSTS						nared
Cost Center Description         Non Physician Anesthetist Cost         Nursing School         Allied Health Medical Education Cost (sum of col through col. 4)         Total Cost (sum of col through col. 4)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         50.00           50.00         05000 (OPERATING ROOM 0 0 0 0         0         0         0         0         0         0           50.00         05000 (APESTHESI OLOGY 0 0 0         0         0         0         0         0         0         50.00           54.00         05400 (RADIOLOGY – DI AGNOSTI C         0         0         0         0         58.00           60.00         06000 LABORATORY         0         0         0         0         0         0         62.00         06250 (Miole BLOOD & PACKED RED BLOOD CELL         0         0         0         0         62.00         06250 (RESPI RATORY THERAPY         0         0         0         66.00         62.30         66.00					10 12/01/2010		
Anesthetist Cost         Medical Education Cost         (sum of col 1 through col. 4)           1.00         2.00         3.00         4.00         5.00           ANCILLARY SERVICE COST CENTERS         0         0         0         0         50.00           05000         0PERATI NG ROOM         0         0         0         0         0         50.00           54.00         05400         RADI DLOGY-DI AGNOSTI C         0         0         0         0         53.00           54.00         06400         RADI DLOGY-DI AGNOSTI C         0         0         0         0         54.00           58.00         05800         MRI         0         0         0         0         54.00           60.00         06000         LABORATORY         0         0         0         0         68.00           62.00         06200         WHOLE BLODD & PACKED RED BLODD CELL         0         0         0         0         62.30           65.00         06500         RESPI RATORY THERAPY         0         0         0         0         62.30           66.00         06500         RESPI RATORY THERAPY         0         0         0         0         66.00			Title	XVIII	Hospi tal	PPS	
Cost         Education Cost         through col.           4)         1.00         2.00         3.00         4.00         5.00           50.00         05000 0PERATI NG ROM         0         0         0         0         50.00           53.00         05300 ANESTHESI OLOGY         0         0         0         0         53.00           54.00         05400 RADI DLOGY-DI AGNOSTI C         0         0         0         0         54.00           58.00         05800 MRI         0         0         0         0         0         58.00           60.00         06000 LABORATORY         0         0         0         0         0         60.00           62.00         06200 WHOLE BLODD & PACKED RED BLOOD CELL         0         0         0         62.30         65.00         66.00         62.30         65.00         66.00         62.30         65.00         66.00	Cost Center Description	Non Physician N	ursing School	Allied Healt	h All Other	Total Cost	
Image: Note of the service cost centers         1.00         2.00         3.00         4.00         5.00           50.00         05000         OPERATING ROOM         0         0         0         0         0         50.00           53.00         05300         ANESTHESI OLOGY         0         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         53.00           58.00         05800         MRI         0         0         0         0         58.00           60.00         06000 LABORATORY         0         0         0         0         60.00           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           62.00         06250 BLOOD CLOTTING FOR HEMOPHI LI ACS         0         0         0         62.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         0         65.00           66.00         06600 PHYSI CAL THERAPY         0         0         0         0         65.00           67.00         00         0         0         0         0         0         72.00							
1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS		Cost			Education Cost		
ANCI LLARY SERVICE COST CENTERS           50.00         05000 (PFERTING R00M         0         0         0         0         50.00           53.00         05300 ANESTHESI OLOGY         0         0         0         0         53.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         54.00           58.00         05800 MRI         0         0         0         0         0         58.00           60.00         06000 LABORATORY         0         0         0         0         0         60.00         62.00           62.00         V6200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         0         62.00							
50.00       05000       0PERATI NG ROOM       0       0       0       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       53.00         58.00       05800       MRI       0       0       0       0       0       58.00         60.00       06000       LABORATORY       0       0       0       0       0       68.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0       62.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.30         65.00       06500       RESTI RATORY THERAPY       0       0       0       0       62.30         65.00       06600       PHYSI CAL THERAPY       0       0       0       0       65.00         66.00       06000       ELCTROCARDI OLOGY       0       0       0       0       0       0       67.00         71.00		1.00	2.00	3.00	4.00	5.00	
53.00       05300       ANESTHESI OLOGY       0       0       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54.00         58.00       05800       MRI       0       0       0       0       0       58.00         60.00       05800       MRI       0       0       0       0       0       58.00         60.00       06000       LABORATORY       0       0       0       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0       62.00         62.00       06250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06400       PHYSI CAL THERAPY       0       0       0       0       66.00         69.00       CALTOR ARGED TO PATI ENT       0       0       0       0       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       72.00		ı		1		1	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       0       0       58.00       0       58.00       0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>Ű</td> <td></td>		0	0		0 0	Ű	
58.00       05800       MRI       0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></td<>		0	0		0 0	-	
60.00       06000       LABORATORY       0		0	0		0 0	-	
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0       62.00         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         69.00       06600       ELCTROCARDI OLOGY       0       0       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 PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.97       OAGPS       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.97         76.98       OYG98       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         76.99       OUTPATI ENT SERVICE COST CENTERS       0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>Ű</td><td></td></td<>		0	0		0 0	Ű	
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         76.97       OARDI AC REHABI LI TATI ON       0       0       0       0       76.97         76.98       07697       LI THOTRI PSY       0       0       0       0       76.99         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       90.00		0	0		0 0	, o	
65.00       06500       RESPI RATORY THERAPY       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       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         76.99       07697       LITHOTRI PSY       0       0       0       0       76.98         00       09000       CLINIC       0       0       0       0       0       76.99		0	0		0 0	0	
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       0       76.98         70.09       09000       CLINI C       0       0       0       0       0       90.00		0	0		0 0	0	
69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       0       76.98         90.00       09000       CLINIC       0       0       0       0       0       76.98		0	0		0 0	0	
71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0         0         0         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         73.00           76.97         07697         CARDIA C REHABILITATION         0         0         0         0         76.97           76.98         07698         HYPERBARIC OXYGEN THERAPY         0         0         0         0         76.98           76.99         07699         LITHOTRIPSY         0         0         0         0         76.98           76.99         07699         LITHOTRIPSY         0         0         0         0         76.98           76.99         07699         LITHOTRIPSY         0         0         0         0         76.99           0UTPATIENT SERVICE COST CENTERS         UTPATIENT SERVICE COST CENTERS         0         0         0         0         90.00		0	0		0 0	0	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         76.97       07697       CARDIA C. REHABILITATION       0       0       0       0       76.97         76.98       07698       HYPERBARI C. OXYGEN THERAPY       0       0       0       0       76.98         76.99       07699       LI THOTRIPSY       0       0       0       0       76.98         70.00       07699       LI THOTRIPSY       0       0       0       0       76.99         0UTPATIENT SERVICE COST CENTERS       0       0       0       0       0       0       0         90.00       09000       CLINIC       0       0       0       0       90.00       90.00		0	0		0 0	0	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       0       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       0       76.99         00       07699       CLI NI C       COST CENTERS       0       0       0       0       90.00		0	0		0 0	0	
76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       0       76. 98         76. 99       07699       LI THOTRI PSY       0       0       0       0       0       76. 99         00       07699       LI THOTRI PSY       0       0       0       0       76. 99         00       07699       CLI NI C       COST CENTERS       76. 99       76. 99       76. 99         90. 00       09000       CLI NI C       0       0       0       0       90. 00		0	0		0 0	0	
76.98         07698         HYPERBARI C 0XYGEN THERAPY         0         0         0         0         76.98           76.99         07699         LI THOTRI PSY         0         0         0         0         0         76.98           00         01         0         0         0         0         0         76.98           90.00         09000         CLI NI C         0         0         0         0         90.00		0	0		0 0	0	
76.99         O7699         LI THOTRI PSY         O         O         O         O         O         O         O         P           90.00         09000         CLI NI C         O         O         O         O         0         0         0         0         90.00		0	0		0 0	0	
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         0         0         0         90.00		0	0		0 0	0	
90. 00 09000 CLINIC 0 0 0 0 0 90. 00		0	0		0 0	0	76.99
92. 00  09200 0BSERVATI ON BEDS (NON-DI STINCT PART   0  0  0  0  92. 00		0	0		0 0	0	
		0	0		0 0	-	
200.00           Total (lines 50-199)         0<	200.00  Total (lines 50-199)	0	0		0 0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0167         Period: For 01/01/270         Period: Part IV Date/Time Prepared: 6/28/27017 9: 42 am           Image: Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Total Charges (col. 5 + col. 7)         Total of Cost Cost Center Description         Inpatient Outpatient Cost (sum of col. 2, 3 and 4)         Inpatient Provider CN: 15-0167         Period: For 01/01/270         Inpatient Program Col. 5 + col. 7)         Inpatient Program Col. 6 + col. 7)           ANCILLARY SERVICE COST CENTERS         0         7.00         8.00         9.00         0.000000         24,753,803         50.00           50.00         05300 ANESTHESI OLOGY         0         147,932,943         0.000000         0.000000         24,753,803         50.00           54.00         05300 ANESTHESI OLOGY         0         2,770,324         0.000000         0.000000         24,753,803         50.00           62.00         06000 UHBORATINEY         0         2,049,163         0.000000         0.000000         717,466         62.30           64.00         06250 RESPI RATORY         0         2,049,163         0.000000         0.000000         0.000000         0.000000         62.30           65.00         06500 RESPI RATORY THERAPY         0         4,14	Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
ANCI LLARY SERVICE COST CENTERS         Total Outpatient Cost (sum of ed. 2, 3 and 4)         Total Color Total Conges (col. 5 + col. 8)         Total Color Color (col. 5 + col. 7)         Outpatient Ratio of Cost to Charges (col. 5 + col. 7)         Inpatient Ratio of Cost to Charges (col. 5 + col. 7)         Inpatient Ratio of Cost to Charges (col. 5 + col. 7)         Inpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Charges           ANCI LLARY SERVICE COST CENTERS         0         7.00         8.00         9.00         10.00           50.00         05000 OPERATING ROOM 53.00         0         147, 932, 943         0.000000         0.000000         2.227, 5183         50.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         12, 595, 719         0.000000         0.000000         2.222, 548, 50.00           60.00         0 66000 LABORATORY         0         2, 770, 324         0.000000         0.000000         13, 440         58.00           62.30         06520 BLODD CLTITING FOR HEMOPHI LLACS         0         0         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.000000         0.02, 00000         0.000000         0.000000         0.000000		RVICE OTHER PASS	S Provider C				
ANCI LLARY SERVICE COST CENTERS         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total (from Wkst. C, Part I, col. 8)         Ratio of Cost to Charges (col. 5 + col. 7)         Unpatient Outpatient (col. 5 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         055000 (OPERATI NG ROOM 53.00         05300 ANESTHESI OLOGY         0         147, 932, 943         0.000000         0.000000         2, 222, 581         53.00           54.00         05600 OPERATI NG ROOM         0         9, 716, 994         0.000000         0.000000         2, 222, 581         53.00           55.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         9, 716, 994         0.000000         0.000000         717, 406         60.00           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         130, 841         0.000000         0.000000         62.00           65.00         06500 RESPI RATORY THERAPY         0         8, 205         0.000000         0.000000         0.000000         0.62.30           65.00         06600 PHYSICAL THERAPY         0         31	THROUGH COSTS						narod
Cost Center Description         Total Outpatient Cost (sum of col. 2, 3 and 4)         Total Total Charges (col. 5 + col. 7)         Ratio of Cost to Charges (col. 5 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)         Program Charges (col. 6 + col. 7)           50.00         05000         0PERATING ROOM 4)         0         147, 932, 943 0.000000         0.000000 0.000000         0.000000 24, 753, 803 52.00         50.00           50.00         05000         0PERATING ROOM 0         0         147, 932, 943 0.000000         0.000000 0.000000         0.000000 24, 753, 803 52.00         50.00           53.00         05300         ANESTHESI 0LOGY 0         0         2, 770, 324 0.000000         0.000000 0.000000         24, 753, 803 53.00         50.00           54.00         05400         ANESTHESI 0LOGY 0         0         2, 770, 324 0.000000         0.000000 0.000000         717, 406 60.00           62.00         06200         WAIL         BLOOD CELL 0         0         30, 841 0.000000         0.000000 0.000000         0         62.00           62.00         064200         VEXEED RED BLOOD CELL 0         0         130, 841 0.000000         0.000000         0.000000         0         62.00           63.00         065000         RESPI RATORY THERAPY 0         0         820, 117 0.0000000         0.000000         0.00					10 12/31/2010		
Outpatism of Cost (sum of col. 2, 3 and 4)         (from Wkst. C Part I, col. 8)         to Charges (col. 5 + col. 7)         Ratio of Cost to Charges (col. 6 + col. 7)         Program Charges           50.00         05000         OPERATING ROOM         0         147, 932, 943         0.000000         0.000000         24, 753, 803         50.00           50.00         05000         OPERATING ROOM         0         147, 932, 943         0.000000         0.000000         24, 753, 803         50.00           53.00         05300         ANESTHESI OLOGY         0         12, 595, 719         0.000000         0.000000         2, 222, 581         53.00           54.00         05400         RATIOLOGY - DI ARNOSTI C         0         2, 770, 324         0.000000         0.000000         76, 239         54.00           60.00         LABORATORY         0         2, 049, 163         0.000000         0.000000         717, 406         60.00           62.00         06200         WHOLE BLODD & PACKED RED BLODD CELL         0         130, 841         0.000000         0.000000         0.000000         62.00           65.00         06500         RESPI RATORY THERAPY         0         4, 144, 426         0.000000         0.000000         198, 317         65.00           66.00			Title	XVIII	Hospi tal		
Cost         (sum of ci l 2, 3 and 4)         Part I, col . 8)         (col . 5 + col . 7)         (to Charges (col . 6 + col . 7)         Charges (col . 6 + col . 7)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           ANCI LLARY SERVICE COST CENTERS         0         147,932,943         0.000000         0.000000         24,753,803         50.00           53.00         05400 RADI OLOGY-DI AGNOSTI C         0         2,770,324         0.000000         0.000000         796,239         54.00           58.00         05800 MRI         0         9,716,998         0.000000         0.000000         717,466         60.00           60.00         66000         LABORATORY         0         2,049,163         0.000000         0.000000         717,466         60.00           62.30         06250         BLOOD & PACKED RED BLOOD CELL         0         130,841         0.000000         0.000000         62.30           65.00         06500         RESPI RATORY THERAPY         0         820,117         0.000000         0.000000         62.30           66.00         06600         PHENDPHI LI ACS         0         0         0         0         313,315,710         0.000000         1,313,31039	Cost Center Description		Total Charges	Ratio of Cost	0utpati ent	Inpati ent	
col. 2, 3 and 4)         8)         7)         (col. 6 + col. 7)         (col. 6 + col. 7)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000 (DPERATI NG ROM         0         147, 932, 943         0.000000         0.000000         24, 753, 803         50.00           53.00         05300 ANESTHESI OLOGY         0         12, 595, 719         0.000000         0.000000         79, 6239         54.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         2, 770, 324         0.000000         0.000000         79, 6239         54.00           58.00         05600 MRI         0         9, 716, 998         0.000000         0.000000         79, 6239         54.00           60.00         06000 LABORATORY         0         2, 049, 163         0.000000         0.000000         60.00           62.00         06500 RESPI RATORY THERAPY         0         820, 117         0.000000         0.000000         62.00           64.00         06500 RESPI RATORY THERAPY         0         8,805         0.000000         0.000000         62.00           65.00         06500 RESPI RATORY THERAPY         0         8,805         0.000000         0.000000							
4)         7)         7)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000         OPERATING ROOM         0         147,932,943         0.000000         0.000000         24,753,803         50.00           53.00         05300         ANESTHESI 0LOGY         0         12,595,719         0.000000         0.000000         2,222,581         53.00           54.00         O5400         RADI OLOGY-DI AGNOSTI C         0         2,770,324         0.000000         0.000000         796,239         54.00           58.00         05800 MRI         0         9,716,998         0.000000         0.000000         717,406         60.00           60.00         06000         LABORATORY         0         2,049,163         0.000000         0.000000         62.00         62.00           62.30         06250         BLOOD CLOTTI NG FOR HEMOPHI LI ACS         0         0         0.000000         0.000000         62.00         62.00           65.00         06500         RESPI RATORY THERAPY         0         4,144,426         0.000000         0.000000         1,31,31,039         66.00           69.00         066000         PLECTROCARDI				·		Charges	
6.00         7.00         8.00         9.00         10.00           ANCI LLARY SERVICE COST CENTERS			8)	7)			
ANCI LLARY SERVICE COST CENTERS           50.00         05000 OPERATI NG ROOM         0         147, 932, 943         0.000000         24, 753, 803         50.00           53.00         05300 ANESTHESI OLOGY         0         12, 595, 719         0.000000         2, 222, 581         53.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         2, 770, 324         0.000000         0.000000         796, 239         54.00           58.00         05800 MRI         0         9, 716, 998         0.000000         0.000000         796, 239         54.00           60.00         06000         LABORATORY         0         2, 049, 163         0.000000         0.000000         717, 406         60.00           62.30         06250         BLOOD CLUTTI NG FOR HEMOPHI LI ACS         0         0         0.000000         0.000000         0.000000         62.30           65.00         06600         PHYSI CAL THERAPY         0         820,117         0.000000         0.000000         1,331,039         66.00           66.00         06600         PHYSI CAL THERAPY         0         88,805         0.000000         0.000000         2,673,020         71.00           71.00         07100         MEI CAL THERAPY         0					• /		
50.00       05000       0PERATI NG ROOM       0       147, 932, 943       0.000000       24, 753, 803       50.00         53.00       05300       ANESTHESI OLOGY       0       12, 595, 719       0.000000       0.000000       2, 222, 581       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       2, 770, 324       0.000000       0.000000       796, 239       54.00         58.00       05800       MRI       0       9, 716, 998       0.000000       0.000000       717, 406       60.00         60.00       06000       LABORATORY       0       2, 049, 163       0.000000       0.000000       717, 406       60.00         62.00       06250       BLODD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0.000000       0.000000       162.30         65.00       06500       RESTI RATORY THERAPY       0       820, 117       0.000000       0.000000       1, 331, 033       66.00         64.00       06000       LHECTROCARDI OLOGY       0       38, 805       0.000000       0.000000       1, 331, 039       66.00         65.00       06900       ELECTROCARDI OLOGY       0       38, 805       0.000000       0.000000       2, 673, 020       71.00		6.00	7.00	8.00	9.00	10.00	
53.00       05300       ANESTHESI OLOGY       0       12, 595, 719       0.000000       0.000000       2, 222, 581       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       2, 770, 324       0.000000       0.000000       796, 239       54.00         58.00       05800       MRI       0       9, 716, 998       0.000000       0.000000       796, 239       54.00         60.00       06000       LABORATORY       0       2, 049, 163       0.000000       0.000000       0       62.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       130, 841       0.000000       0.000000       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       820, 117       0.000000       0.000000       1, 331, 039       66.00         66.00       06600       PHYSI CAL THERAPY       0       4, 144, 426       0.000000       0.000000       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       31, 315, 710       0.000000       0.000000       2, 649, 03         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       100, 928, 644       0.000000       0.000000       2, 657, 851<			4.47.000.040	0.00000		04 750 000	50.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       2,770,324       0.000000       0.000000       796,239       54.00         58.00       05800       MRI       0       9,716,998       0.000000       0.000000       13,440       58.00         60.00       06000       LABORATORY       0       2,049,163       0.000000       0.000000       717,406       60.00         62.00       06200       WHOLE       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0.000000       0.000000       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       820,117       0.000000       0.000000       1,331,039       66.00         66.00       06600       PHYSI CAL THERAPY       0       4,144,426       0.000000       0.000000       1,331,039       66.00         69.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       2,673,020       71.00         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       31,315,710       0.000000       0.000000       2,607,851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000		0					
58.00       05800       MRI       0       9,716,998       0.000000       0.000000       13,440       58.00         60.00       06000       LABORATORY       0       2,049,163       0.000000       0.000000       717,406       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       130,841       0.000000       0.000000       0       62.00         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0.000000       0.000000       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       820,117       0.000000       0.000000       1,331,037       65.00         66.00       06600       PHYSI CAL THERAPY       0       4,144,426       0.000000       0.000000       1,331,037       65.00         67.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       0       69.00         71.00       07100       MEL CAL SUPPLIES CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000       26,057,851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16,392,744       0.0000000       0.0000000       0		0					
60.00         06000         LABORATORY         0         2,049,163         0.000000         0.000000         717,406         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         130,841         0.000000         0.000000         0         62.00           62.30         06250         BLOOD CLOTTING FOR HEMOPHI LIACS         0         0         0.000000         0.000000         0         62.00           65.00         06500         RESPI RATORY THERAPY         0         820,117         0.000000         0.000000         1,331,039         65.00           66.00         06600         PHYSI CAL THERAPY         0         4,144,426         0.000000         0.000000         1,331,039         66.00           69.00         06900         ELECTROCARDI OLOGY         0         38,805         0.000000         0.000000         2,673,020         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         0         100,928,644         0.000000         0.000000         2,6,673,020         71.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         100,928,644         0.000000         0.000000         0.000000         0.0000000         0.0000000 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       130, 841       0.000000       0.000000       0       62.00         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0.000000       0.000000       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       820,117       0.000000       0.000000       198,317       65.00         66.00       06600       PHYSI CAL THERAPY       0       4,144,426       0.000000       0.000000       1,331,039       66.00         69.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       2,673,020       71.00         71.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000       2,6,057,851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16,392,744       0.000000       0.000000       3,938,157       73.00         76.97       OA694       HYPERBARI C OXYGEN THERAPY       0       0       0.000000       0.000000       0       76.97         76.99       07697 LARDI AC REHABI LI TATI ON       0       0       0.000000       0.000000		0					
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0.000000       0.000000       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       820,117       0.000000       0.000000       198,317       65.00         66.00       06600       PHYSI CAL THERAPY       0       4,144,426       0.000000       0.000000       1,331,039       66.00         69.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       2,673,020       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       31,315,710       0.000000       0.000000       2,673,020       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000       2,6,057,851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16,392,744       0.000000       0.000000       3,938,157       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0.000000       0.000000       0       66.98         90.00       07699       LI THOTRI PSY       0       0       0.000000       0.000000<		0					
65.00       06500       RESPI RATORY THERAPY       0       820,117       0.000000       198,317       65.00         66.00       06600       PHYSI CAL THERAPY       0       4,144,426       0.000000       0.000000       1,331,039       66.00         69.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       2,673,020       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       31,315,710       0.000000       0.000000       2,673,020       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000       3,938,157       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16,392,744       0.000000       0.000000       3,938,157       73.00         76.97       OR697       CARDI AC REHABILI TATI ON       0       0       0.000000       0.000000       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0.000000       0.000000       0       76.98         90.00       09000       CLINIC       0       0       0.000000       0       0       0		0					
66.00       06600       PHYSI CAL THERAPY       0       4, 144, 426       0.000000       0.000000       1, 331, 039       66.00         69.00       06900       ELECTROCARDI OLOGY       0       38, 805       0.000000       0.000000       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       31, 315, 710       0.000000       0.000000       2, 673, 020       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       100, 928, 644       0.000000       0.000000       26, 057, 851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16, 392, 744       0.000000       0.000000       3, 938, 157       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0.000000       0.000000       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0.000000       0.000000       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0.000000       0       76.98         90.00       09000       CLI NI C       OST CENTERS       0       0       0.000000       0       76.98		0	e e				
69.00       06900       ELECTROCARDI OLOGY       0       38,805       0.000000       0.000000       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       31,315,710       0.000000       0.000000       2,673,020       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       100,928,644       0.000000       0.000000       26,057,851       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       16,392,744       0.000000       0.000000       3,938,157       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0.000000       0.000000       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0.000000       0.000000       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0.000000       0       76.98         70.00       09000       CLI NI C       0       0       0.000000       0       0       90.00		0					
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENT         0         31, 315, 710         0.000000         2, 673, 020         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         100, 928, 644         0.000000         26, 057, 851         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         16, 392, 744         0.000000         0.000000         3, 938, 157         73.00           76.97         07697         CARDI AC REHABI LI TATI ON         0         0         0.000000         0.000000         0         76.97           76.98         07698         HYPERBARI C OXYGEN THERAPY         0         0         0         0.000000         0         76.98           76.99         07699         LI THOTRI PSY         0         0         0.000000         0.000000         0         76.98           90.00         09000         CLINIC         COST CENTERS		0				1	
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0         100, 928, 644         0.000000         0.000000         26, 057, 851         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         16, 392, 744         0.000000         0.000000         3, 938, 157         73.00           76.97         07697         CARDIA C. REHABILITATION         0         0         0.000000         0.000000         0         76.97           76.98         07699         LITHOTRIPSY         0         0         0.000000         0.000000         0         76.98           76.99         07699         LITHOTRIPSY         0         0         0.000000         0.000000         0         76.98           00         07699         LITHOTRIPSY         0         0         0.000000         0         76.98           00         00         0.000000         0.000000         0         0         0         0.000000         0         76.98           76.99         01THATIENT SERVICE COST CENTERS         0         0         0.000000         0         0         0         0         0         0         0         0         0         0         0		0					
73.00       07300       DRUGS CHARGED TO PATIENTS       0       16, 392, 744       0.000000       0.000000       3, 938, 157       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0.000000       0.000000       0       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0.000000       0.000000       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0.000000       0.000000       0       76.99         0UTPATI ENT SERVICE COST CENTERS       0       0       0.000000       0.000000       0       90.00		0					
76. 97       07697       CARDI AC REHABI LI TATI ON       0       0       0.000000       0.000000       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0.000000       0.000000       0       76. 98         76. 99       07699       LI THOTRI PSY       0       0       0.000000       0       76. 98         90. 00       09000       CLI NI C       0       0       0.000000       0       90. 00		0					
76.98         07698         HYPERBARI C 0XYGEN THERAPY         0         0         0.000000         0.000000         0         76.98         76.98         76.99         0.000000         0         0.000000         0         76.98         76.99 <td></td> <td>0</td> <td>16, 392, 744</td> <td></td> <td></td> <td></td> <td></td>		0	16, 392, 744				
76. 99         07699         LI THOTRI PSY         0         0         0.000000         0         76. 99           OUTPATI ENT SERVICE COST CENTERS         0         0         0.000000         0.000000         0         90. 00           90. 00         09000         CLI NI C         0         0         0.000000         0         90. 00		0	0			-	
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         0         0.000000         0.000000         0         90.00		0	0				
90.00 09000 CLINIC 0 0 0.000000 0.000000 0 90.00		0	0	0.00000	0 0.000000	0	76.99
				1			
92. 00  09200  0BSERVATI ON BEDS (NON-DISTINCT PART   0  274, 427 0. 000000  0. 000000  0  92. 00		0	0				
		0			0 0.000000		
200. 00       Total (lines 50-199)       0       329, 110, 861       62, 701, 853 200. 00	200.00   Total (lines 50-199)	0	329, 110, 861			62, 701, 853	200. 00

APPORTI ONNENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0167         Period: From 01/01/2016 From 01/01/2016         Worksheet D Part IV Date/Time Prepared: 6/28/2017 9:42 am           Cost Center Description         Inpatient Program Pass-Through Costs (col. 9 x col. 10)         Title XVIII         Hospital         PPS           ANCILLARY SERVICE COST CENTERS         0         12.00         12.00         13.00           ANCILLARY SERVICE COST CENTERS         0         341,003         50.00         53.00           50.00         05000 OPERATING ROOM         0         4,348,521         0         50.00           54.00         05400 ANESTHESIOLOGY         0         341,003         0         54.00           54.00         06000 LABORATORY         0         4,742         0         58.00           62.00         06200 WILE BLODD & PACKED RED BLODD CELL         0         0         0         62.00           62.00         062000 WILE BLODD & PACKED RED BLODD CELL         0         0         0         62.00           63.00         063000 PHYSICAL HERAPY         0         3,432         0         62.00           64.00         0         0         0         0         0         62.00           65.00         06000 PHY	Health Financial Systems	ORTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
Anci LLARY SERVICE COST CENTERS         Inpatient         Outpatient         Outpatient         Outpatient         Outpatient         Outpatient         Outpatient         Program Pro		RVICE OTHER PASS	Provider C	CN: 15-0167			
ANCILLARY SERVICE COST CENTERS         Inpati ent Program Pass-Through Costs (col. 8 x col. 10)         Outpati ent Program Charges         Outpati ent Program Pass-Through Costs (col. 9 x col. 12)         Solution Pass-Through Costs (col. 9 x col. 12)         Solution Pass-Through Costs (col. 9 x col. 12)           ANCILLARY SERVICE COST CENTERS         0         4,348,521         0         50.00           05300 OPERATING ROOM 05300 ANESTHESI OLOGY         0         4,348,521         0         53.00           54.00         05300 ANESTHESI OLOGY         0         341,003         0         54.00           58.00         05600 KRI         0         817,112         0         58.00           62.20         06020 LOTTIN GR PORMERD RED BLOOD CELL         0         0         0         60.00           62.20         06500 RESPI RATORY         0         3,432         0         65.00         65.00           66.00         06600 PHYSI CAL THERAPY         0         0         0         0         66.00         66.00         67.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         76.97         76.97         76.97         76.97         76.9	THROUGH COSTS						narod
Cost Center Description         Inpatient Program Pass-Through Costs (col. 8 x col. 10)         Outpatient Program Charges         Outpatient Program Charges           ANCILLARY SERVICE COST CENTERS         0         x col. 10)         x col. 12)         x col. 12)           11.00         12.00         13.00         50.00         05300 (ARESTHESI OLOGY         0         4, 348, 521         0           53.00         05300 (ARESTHESI OLOGY         0         341,003         0         53.00         53.00           54.00         05600 (MRI PADI OLOGY - DI AGNOSTI C         0         72,021         0         54.00           62.00         06200 (MALESTHESI OLOGY         0         817,112         0         60.00           62.00         062200 (MALE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           62.00         06500 RESPI RATORY THERAPY         0         3,432         0         65.00           64.00         0600 LECTCOCARDI OLOGY         0         0         0         72.00           65.00         06500 RESPI RATORY THERAPY         0         3,432         0         65.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         71.00           71.00					10 12/31/2010	6/28/2017 9:4	2 am
Program Pass-Through Costs (col. 9 x col. 10)         Program Charges         Program Pass-Through Costs (col. 9 x col. 12)           ANCI LLARY SERVICE COST CENTERS         11.00         12.00         13.00           50.00         05000 OPERATING ROOM         0         4,348,521         0           53.00         05300 ANESTHESI OLOGY         0         341,003         0           54.00         05400 RADI OLOGY-DIAGNOSTI C         0         72,021         0           58.00         05800 MRI         0         817,112         0           60.00         06200 UHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0           60.00         06000 CLABORATORY         0         4,742         0         62.00           65.00         06500 RESPI RATORY THERAPY         0         3,432         0         65.00           66.00         06000 CLATH REAPY         0         0         0         65.00           67.00         0         0         0         0         72.00         72.00           67.00         06000 CLABORATORY         0         0         0         62.00         62.00           65.00         00         0         0         0         0         0         72.00 <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Hospi tal</td> <td>PPS</td> <td></td>			Title	XVIII	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS         Charges         Pass-Through Costs (col. 9 x col. 12)         Pass-Through Costs (col. 9 x col. 12)           MICI LLARY SERVICE COST CENTERS         0         11.00         12.00         13.00           50.00         05000         OPERATI NG ROOM         0         4, 348, 521         0           53.00         05300         ANESTHESI OLOGY         0         341, 003         0           54.00         05800         MRI         0         817, 112         0           60.00         06000         LABORATORY         0         817, 112         0           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           65.00         06500         RESPI RATORY THERAPY         0         3, 432         0         62.00           66.00         06900         ELCTROCARDI OLOGY         0         0         0         62.00           65.00         06500         RESPI RATORY THERAPY         0         3, 432         0         65.00           66.00         06900         ELCTROCARDI OLOGY         0         0         0         71.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATI ENTS	Cost Center Description						
ANCILLARY SERVICE COST CENTERS         Costs (col. 8 x col. 10)         Costs (col. 9 x col. 12)           11.00         12.00         13.00           50.00         05000         OPERATING ROOM         0         4,348,521         0           50.00         05300         ANESTHESI OLOGY         0         341,003         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         72,021         0         54.00           58.00         05800         NRI         0         4,742         0         60.00         62.00							
x col. 10)         x col. 12)           11.00         12.00         13.00           50.00         05000         OPERATI NG ROOM         0         4,348,521         0           53.00         05300         ANETHESI OLOGY         0         341,003         0         53.00           54.00         05800         MRI         0         817,112         0         58.00           60.00         06000         LABORATORY         0         817,112         0         58.00           61.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           65.00         06500         RESPI RATORY THERAPY         0         3,432         0         65.00           66.00         06000         PHYSICAL THERAPY         0         0         0         69.00           69.00         06000         ELECTROCARDI OLOGY         0         0         0         71.00           71.00         07300         DRUGS CHARGED TO PATI ENTS         0         1,138,794         0         72.00           73.00			Charges				
In .00         12.00         13.00           ANCI LLARY SERVICE COST CENTERS         50.00         0PERATI NG ROOM         0         4, 348, 521         0           50.00         05300         ANESTHESI OLOGY         0         341, 003         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         72, 021         0         54.00           58.00         05300         MRI         0         817, 112         0         60.00           60.00         06000         LABORATORY         0         4, 742         0         62.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           65.00         06500         RESPI RATORY THERAPY         0         3, 432         0         65.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         67.00           64.00         06000         LHEAPY         0         0         0         65.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         65.00           65.00         06600         PHYSI CAL THERAPY         0					9		
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         0         4, 348, 521         0           53.00         05300         ANESTHESI OLOGY         0         341, 003         0           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         72, 021         0           58.00         05800         MRI         0         817, 112         0         58.00           60.00         06000         LABORATORY         0         4, 742         0         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.30           65.00         06500         RESPI RATORY THERAPY         0         3, 432         0         65.00           64.00         0         0         0         0         0         66.00           65.00         06500         RESPI RATORY THERAPY         0         0         0         66.00           69.00         CHECTROCARDI OLOGY         0         0         0         0         66.00           69.00         OTOO         0         0         0         0         71.00         72.00           71.00							
50.00         05000         OPERATING ROOM         0         4, 348, 521         0           53.00         05300         ANESTHESI 0LOGY         0         341, 003         0           54.00         05400         RADI 0LOGY-DI AGNOSTI C         0         72, 021         0           58.00         05800         MRI         0         817, 112         0         58.00           60.00         06000         LABORATORY         0         4, 742         0         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           65.00         06500         RESPI RATORY         HEMOPHI LI ACS         0         0         0         62.30           65.00         06600         PHYSI CAL. THERAPY         0         3, 432         0         66.00           69.00         06900         ELECTROCARDI OLOGY         0         0         0         69.00           71.00         07100         MEDL CAL SUPPLI ES CHARGED TO PATI ENT         0         568,004         0         71.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         1,138,794         0         73.00         73.00		11.00	12.00	13.00			
53.00       05300       ANESTHESI OLOGY       0       341,003       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       72,021       0       54.00         58.00       05800       MRI       0       817,112       0       60.00       60.00         60.00       06000       LABORATORY       0       4,742       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       3,432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       64.00         69.00       06900       ELECTROCARDI OLOGY       0       0       64.00       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1, 138, 794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290, 905       73.00       76.97         76.97       ORAPUS CHARGED TO PATI ENTS		-		1	-		
54.00       05400       RADI OLOGY - DI AGNOSTI C       0       72, 021       0         58.00       05800 MRI       0       817, 112       0       58.00         60.00       06000       LABORATORY       0       4, 742       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00         62.00       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       3, 432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       LECTROCARDI OLOGY       0       0       0       69.00         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       568,004       0       71.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       290,905       73.00       73.00         76.97       OR698 HYPERBARI C OXYGEN THERAPY       0       0       0       76.97         76.98       07699 LI THOTRI PSY       0       0       0       0       76.97         76.98       07698 HYPERBARI C OX		0			0		
58.00       05800       MRI       0       817, 112       0       58.00         60.00       06000       LABORATORY       0       4, 742       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       3, 432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       06900       ELECTROCARDI 0LOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       1, 138, 794       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       290, 905       0       73.00         76.97       7G498       HYPERBARI C 0XYGEN THERAPY       0       0       0       76.98         76.99       OT699 LI THOTRI PSY       0       <		0			0		
60.00       06000       LABORATORY       0       4,742       0       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       3,432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       66.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       0       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       76.97         76.98       07699       HYPERBARI C OXYGEN THERAPY       0       0       0       76.98         76.99       07699       LI THOTRI PSY		0			0		
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00         62.30       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       3,432       0       65.00         66.00       06000       PHYSI CAL THERAPY       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       0       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       76.97         76.98       NYPERBARI C OXYGEN THERAPY       0       0       0       76.98         76.98       07699       LI THOTRI PSY       0       0       0       76.98         76.99       07699       CI THENT SERVICE COST CENTERS       0<		0			0		
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       3,432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       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       76.97         76.98       07699       LI THOTRI PSY       0       0       0       76.98         76.99       07699       CLI NI C       0       0       0       90.00         90.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0		0	4, 742		0		
65.00       06500       RESPI RATORY THERAPY       0       3, 432       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       0       73.00         76.97       OARDI AC REHABI LI TATI ON       0       0       0       76.97         76.98       07699       LTHOTRI PSY       0       0       0       76.98         76.98       07699       UTPATI ENT SERVICE COST CENTERS       0       0       0       76.98         90.00       09000       CLI NI C       0       0       0       90.00       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       17,200       0       92.00		0	0		0		
66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       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       76.98         70.00       09000       CLI NI C       0       0       0       76.99         90.00       09000       CLI NI C       0       0       0       90.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       17.200       0       92.00		0	0		0		
69.00       06900       ELECTROCARDIOLOGY       0       0       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       290,905       0       73.00         76.97       07697       CARDIA C REHABILITATION       0       0       0       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       0       0       76.98         76.99       07499       LITHOTRIPSY       0       0       0       76.98         90.00       09000       CLINIC       COST CENTERS       90.00       90.00       90.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       17,200       0       92.00		0	3, 432		0		
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       568,004       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       1,138,794       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       290,905       0       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       76.97         76.98       07699       HYPERBARI C OXYGEN THERAPY       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       76.98         70.00       09000       CLI NI C       0       0       0       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       17,200       0       92.00		0	0		0		
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       1, 138, 794       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       290, 905       0       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       76.97         76.98       07699       LITHOTRIPSY       0       0       0       76.98         07699       LITHOTRIPSY       0       0       0       76.98         00TPATIENT SERVICE COST CENTERS       0       0       0       76.99         00TPATIENT SERVICE COST CENTERS       0       0       0       76.99         90.00       09000       CLINIC       0       0       90.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       17,200       0       92.00		0	0		0		
73.00       07300       DRUGS CHARGED TO PATIENTS       0       290,905       0       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       76.97         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       76.98         76.99       07699       LI THOTRIPSY       0       0       0       76.98         00TPATIENT SERVICE COST CENTERS       0       0       0       76.99         90.00       09000       CLINIC       0       0       90.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       17,200       0       92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0		71.00
76. 97       07697       CARDI AC REHABILI TATI ON       0       0       0       76. 97         76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       76. 98         76. 99       07699       LI THOTRI PSY       0       0       0       76. 99         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       90.00         90. 00       09000       CLI NI C       0       0       90.00       90.00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       17, 200       0       92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 138, 794		0		72.00
76. 98         07698         HYPERBARI C 0XYGEN THERAPY         0         0         0         76. 98         76. 99         90. 00         00         0         00         90. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	290, 905		0		73.00
76. 99         07699         LI THOTRI PSY         0         0         76. 99           OUTPATI ENT SERVICE COST CENTERS         0         0         0         90.00         90000         CLI NI C         90.00<	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         0         0         90. 00           92. 00         09200         OBSERVATION_BEDS_(NON-DISTINCT_PART         0         17, 200         0         92. 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76.98
90.00         09000         CLINIC         0         0         90.00         90.00         92.00         09200         0BSERVATION         BEDS         (NON-DISTINCT PART         0         17,200         0         92.00	76. 99 07699 LI THOTRI PSY	0	0		0		76.99
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 17, 200 0 92. 00							
		0	0		0		
200.00           Total (lines 50-199)         0         7,601,734         0         200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 200		0		92.00
	200.00  Total (lines 50-199)	0	7, 601, 734		0		200.00

Health Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	0.00	(see inst.)	(see inst.)	5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.40/000	4 9 4 9 5 9 4			444.070	50.00
50. 00 05000 OPERATING ROOM	0. 106928			0 0	464, 979	
53. 00 05300 ANESTHESI OLOGY	0. 052916			0 0	18, 045	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 179531			0 0	12, 930	
58. 00 05800 MRI	0. 091005			0 0	74, 361	•
60. 00 06000 LABORATORY	0. 384331			0 0	1, 822	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 260507			0 0	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 165009			0 0	566	
66. 00 06600 PHYSI CAL THERAPY	0. 310366			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 048190			0 0	0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130674			0 0	74, 223	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 254811			0 0	290, 177	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 156101			0 0	45, 411	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 0	0	
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	1		1	1	r	
90. 00 09000 CLI NI C	0. 000000			0 0	-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 493876			0 0	25, 695	
200.00 Subtotal (see instructions)		7, 601, 734		0 0	1, 008, 209	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		7, 601, 734	I	0 0	1, 008, 209	202.00

Health Financial Systems C	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 01/01/2016 To 12/31/2016	6/28/2017 9:4	
			XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
58. 00 05800 MRI	0	0				58.00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems	ORTHOPAEDI C HOS	PT. AT PARKVI EW		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 2 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	0.00	2)	1 00	5.00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	T			
30. 00 ADULTS & PEDIATRICS	462, 901		462, 90			•
200.00 Total (lines 30-199)	462, 901		462, 90	5, 860		200.00
Cost Center Description	Inpatient Program days	Capital Cost (col. 5 x col. 6)	_			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	256 256					30. 00 200. 00

Health Financial Systems (	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	1		
50.00 05000 OPERATING ROOM	1,001,446					
53. 00 05300 ANESTHESI OLOGY	2, 618					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 953				3	54.00
58. 00 05800 MRI	191, 043				0	58.00
60. 00 06000 LABORATORY	3, 093				8	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	134	130, 841			0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	532	820, 117	0. 00064	9 1, 603	1	65.00
66. 00 06600 PHYSI CAL THERAPY	25, 701	4, 144, 426			62	66.00
69. 00 06900 ELECTROCARDI OLOGY	7	38, 805	0.00018	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 072	31, 315, 710	0. 00051	3 15, 900	8	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	100, 988	100, 928, 644	0.00100	1 184, 500	185	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	61, 295	16, 392, 744	0.00373	9 25, 318	95	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	28, 912	274, 427	0. 10535	4 0	0	92.00
200.00 Total (lines 50-199)	1, 433, 794	329, 110, 861		422, 058	1, 449	200.00

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COST			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Allied Health Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30-199)	0	C		0 0	0	30.00 200.00
Cost Center Description	Total Patient Days	5 ÷ col . 6)	Inpatient Program Days	Pass-Through Cost (col. 7 x col. 8)		
	6.00	7.00	8.00	9.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					-	
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30-199)	5, 860 5, 860	0.00	25 25			30. 00 200. 00

Health Financial Systems	ORTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 9:4	pared: 2 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician N Anesthetist Cost	lursi ng School	Allied Healt	h All Other Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
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 I MPL. 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	-	-	1		-	
90. 00 09000 CLINIC	0	0		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0 0	0	
200.00   Total (lines 50-199)	0	0	1	0 0	0	200. 00

Heal th	Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUG	H COSTS				From 01/01/2016	Part IV	norod.
					To 12/31/2016	Date/Time Pre 6/28/2017 9:4	
			Titl	e XIX	Hospi tal	PPS	2 411
	Cost Center Description	Total	Total Charges			I npati ent	
	'	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	ANCI LLARY SERVI CE COST CENTERS	1		1			
	05000 OPERATI NG ROOM	0	147, 932, 943			160, 064	
	05300 ANESTHESI OLOGY	0	12, 595, 719			15, 502	
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 770, 324			3, 598	
58.00	05800 MRI	0	9, 716, 998			0	58.00
	06000 LABORATORY	0	2, 049, 163			5, 558	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	130, 841	0.00000		0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000		0	62.30
	06500 RESPI RATORY THERAPY	0	820, 117			1, 603	
	06600 PHYSI CAL THERAPY	0	4, 144, 426			10, 015	
	06900 ELECTROCARDI OLOGY	0	38, 805			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	31, 315, 710			15, 900	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	100, 928, 644			184, 500	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	16, 392, 744	0.00000	0. 000000	25, 318	73.00
	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.00000	0.00000	0	76.99
	OUTPATIENT SERVICE COST CENTERS				-		
	09000 CLI NI C	0	0	0.00000		0	70.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	274, 427	0.00000	0. 000000	0	12100
200.00	Total (lines 50-199)	0	329, 110, 861			422, 058	200. 00

APPORT IONMENT OF INPATIENT /OUTPATIENT ANCILLARY SERVICE OTHER PASS         Provider CCN: 15-0167         Period: From 01/01/2016 To 12/31/2016         Worksheet 0 Part IV Date/Time Prepared: 6/28/20179:42 am           Cost Center Description         Inpatient Program Pass-Through Costs (col. 9 x col. 10)         Title XIX         Hospital         PPS           ANCILLARY SERVICE COST CENTERS         0utpatient Program Pass-Through Costs (col. 9 x col. 10)         0utpatient Program Pass-Through Costs (col. 9 x col. 12)         0         50.00           ANCILLARY SERVICE COST CENTERS         0         0         0         0         50.00           50.00         05000 (AMESTHESI LOLGY 0 0000 (AMESTHESI LOLGY 0 0         0         0         50.00         53.00           54.00         05400 (ABORATORY 0 0         0         0         0         60.00         60.00         60.00         60.00         62.	Health Financial Systems	ORTHOPAEDIC HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
ANCI LLARY SERVICE COST CENTERS         0         12/31/2016         Date/Time Prepared: 6/28/2017 9:42 am           ANCI LLARY SERVICE COST CENTERS         Inpatient Program Pass-Through Costs (col. 8 x col. 10)         0         0utpatient Program Pass-Through Costs (col. 9 x col. 12)         0         0         0           ANCI LLARY SERVICE COST CENTERS         0         0         0         0         0         0         0         0         50.00         50.00         53.00         50.00         53.00         50.00         53.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         54.00         56.00         62.00         64.00         64.0		RVICE OTHER PASS	Provider C	CN: 15-0167			
ANCILLARY SERVICE COST CENTERS         Inpati ent Program Pass-Through Costs (col. 8 x col. 10)         Outpati ent Program Charges         Poss-Through Pass-Through Costs (col. 9 x col. 12)         50.00           50.00         05300 OPERATING ROOM 05300 OPERATING ROOM 53.00         0         0         0         0         50.00           54.00         05300 ANESTHESI OLOGY         0         0         0         53.00         50.00           54.00         05300 ANESTHESI OLOGY         0         0         0         54.00         54.00         54.00         54.00         54.00         54.00         54.00         56.00         56.00         56.00         66.00         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         66.00         66.00         67.00         71.00         71.00         71.00         71.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         76.97         76.97         76.97         76.97         76.97         76.97         76.97         76.97	THROUGH COSTS						narod
Cost Center Description         Inpatient Program Pass-Through Costs (col. 8 x col. 10)         Outpatient Program Charges         Outpatient Program Charges         Outpatient Program Charges           ANCI LLARY SERVICE COST CENTERS         11.00         12.00         13.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         13.00           ANCI LLARY SERVICE COST CENTERS         0         0         0         50.00           05000 OPERATING ROOM         0         0         0         0         53.00           53.00         05300 ANESTHESI OLOGY         0         0         0         53.00           54.00         05600 IR         0         0         0         0         60.00           60.00         06000 LABORATORY         0         0         0         0         60.00           62.00         06500 RESPI RATORY THERAPY         0         0         0         0         62.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         64.00         66.00         66.00         66.00         66.00         66.00         71.00         71.00         71.00         71.00         72.00         0         0         0         72.00         73.00         7					10 12/31/2010	6/28/2017 9:4	2 am
Program Pass-Through Costs (col. 9 x col. 10)         Program Charges         Program Pass-Through Costs (col. 9 x col. 12)           ANCI LLARY SERVICE COST CENTERS         11.00         12.00         13.00           50.00         05000 0PERATING ROOM         0         0         0         50.00         53.00           53.00         05300 ANESTHESI OLOGY         0         0         0         53.00         53.00           54.00         05400 RADI LOGY-DIAGNOSTI C         0         0         0         58.00         58.00         66.00         62.00         66.00         62.00         66.00         62.00         66.00         62.00         66.00         62.00         66.00         62.00         66.00         62.30         65.00         65.00         66.00         <			Titl	e XIX	Hospi tal	PPS	
ANCI LLARY SERVI CE COST CENTERS         Charges         Pass-Through Costs (col. 9 x col. 12)         Pass-Through Costs (col. 9 x col. 12)           ANCI LLARY SERVI CE COST CENTERS         11.00         12.00         13.00           50.00         05000         OPERATI NG ROOM         0         0         0           53.00         05300         ANESTHESI OLOGY         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         54.00           60.00         065000         MRI         0         0         0         0         54.00           61.00         065000 ARI         0         0         0         0         0         54.00           62.00         06200 WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         0         0         62.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         64.00         66.00           69.00         06900 LLECTROCARDI OLOGY         0         0         0         0         64.00         66.00           69.00         06500 RESPI RATORY THERAPY         0         0         0         0         64.00         69.00         64.0	Cost Center Description						
ANCI LLARY         SERVI CE         COSTS (col. 8 x col. 10)         Costs (col. 9 x col. 12)           11.00         12.00         13.00           50.00         05000         0PERATI 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         MRI         0         0         0         54.00           58.00         06200         HOLDE BLOOD & PACKED RED BLOOD CELL         0         0         0         62.00           60.200         06200 WHOLE         BLOOD CLOTTI NG FOR HEMOPHI LI ACS         0         0         0         62.00           62.30         062508         BLODD CLOTTI NG FOR HEMOPHI LI ACS         0         0         0         62.30           65.00         066000         PHONPHI CHARAPY         0         0         0         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00							
x col. 10)         x col. 12)           11.00         12.00         13.00           50.00         05000         OPERATI NG ROM         0         0         50.00           53.00         05300         AMETHESI OLOGY         0         0         0         53.00           54.00         05300         AMESTHESI OLOGY         0         0         0         53.00           54.00         05800         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         06500         RESPI RATORY THERAPY         0         0         0         65.00           66.00         06600         PHYSI CAL THERAPY         0         0         0         65.00           66.00         06000         ELECTROCARDI OLOGY         0         0         0         66.00           69.00         02000         IMPL. DEV. CHARGED TO PATI ENT         0         0         0         71.00           71.00         07100         MEDI CAL SUPPLIES CHARGED T			Charges				
In the second					9		
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         0         0         0         50.00         50.00         S0.00         ANCI LLARY SERVICE COST CENTERS         50.00         50.00         S0.00         OS000         OPERATI NG ROOM         0         0         0         0         53.00         S0.00         ANCI LLARY SERVICE COST CENTERS         50.00         0         0         0         0         0         0         0         53.00         S0.00         ANESTHESI OLOGY         0         0         0         0         53.00         54.00         0         0         0         0         54.00         54.00         0							
50.00       05000       OPERATI NG ROOM       0       0       0       50.00         53.00       05300       ANESTHESI OLOGY       0       0       0       53.00         54.00       O5400       RADI OLOGY-DI AGNOSTI C       0       0       0       58.00         58.00       O5800       MRI       0       0       0       60.00       60.00         60.00       0       0       0       0       0       0       60.00       60.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       66.00       66.00       66.00       69.00       71.00       71.00       71.00       71.00       71.00       72.00       72.00       72.00<		11.00	12.00	13.00			
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       MRI       0       0       0       0       60.00         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       06500       RESPI RATORY THERAPY       0       0       0       62.30         65.00       06500       RESPI RATORY THERAPY       0       0       0       65.00         64.00       06000       LECTROCARDI OLOGY       0       0       66.00       69.00         64.00       06900       ELECTROCARDI OLOGY       0       0       0       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       71.00         72.00       07200 I IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72.00         76.97       07697 CARDI AC REHABI LI TATI ON       0       0       0       76.97 <td></td> <td></td> <td></td> <td>1</td> <td>-1</td> <td></td> <td></td>				1	-1		
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       54.00         58.00       05800       MRI       0       0       0       58.00         60.00       06000       LABORATORY       0       0       0       60.00         62.00       06200       WHOLE BLOOD & ACKED RED BLOOD CELL       0       0       0       62.00         62.00       06250       BLOOD CLOTTI NG FOR HEMOPHI LI ACS       0       0       0       62.00         65.00       06500       RESPI RATORY THERAPY       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       D6900       ELECTROCARDI OLOGY       0       0       0       69.00         71.00       MDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       71.00         72.00       IMPL       DEV. CHARGED TO PATI ENTS       0       0       0       73.00         76.97       OR598       NPG98       HYPERBARI C OXYGEN THERAPY       0       0       0       76.97         76.98       07699       LI THOTRI PSY       0       0       0       0		0	0		0		
58.00       05800       MRI       0 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0</td><td></td><td></td></td<>		0	C		0		
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 CLOTTI NG FOR HEMOPHI LI ACS       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       65.00         66.00       06900       ELECTROCARDI OLOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       76.98         76.98       07698       HYPERBARI C OXYGEN THERAPY       0       0       0       76.98         76.98       09000       CLINIC       0       0       <		0	C		0		
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       62.00         62.30       06250       BLOOD CLOTTING FOR HEMOPHI LIACS       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       ELECTROCARDIOLOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         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         76.98       07699       LI HOTRI PSY       0       0       0       76.98         90.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART		0	C		0		
62.30       06250       BLOOD CLOTTING FOR HEMOPHILIACS       0       0       62.30         65.00       06500       RESPIRATORY THERAPY       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0         67.00       06900       ELECTROCARDIOLOGY       0       0       0         67.00       06900       ELECTROCARDIOLOGY       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       73.00         76.97       07697       CARDIA C REHABILITATION       0       0       0       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       0       0       76.98         76.98       07699       LITHOTRIPSY       0       0       0       76.98       76.98         70.00       09000       CLINIC       0       0       0       90.00       90.00         92.00       09200       OBSERVAT		0	C		0		
65.00       06500       RESPI RATORY THERAPY       0       0       0       65.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       67.00       77.00       73.00       73.00       70.00       73.00       70.00       73.00       70.00       76.97       76.97       76.98       76.98       76.98       76.98       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       76.99       99       92.00       92.00       0       0       0		0	C		0		
66.00       06600       PHYSI CAL THERAPY       0       0       0       66.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         76.97       07697       CARDI AC REHABI LI TATI ON       0       0       0       76.97         76.98       07699       LI THOTRI PSY       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       76.98         90.00       09000       CLI NI C       0       0       0       90.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00		0	C		0		
69.00       06900       ELECTROCARDIOLOGY       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       OARDIAC REHABILITATION       0       0       0       76.97         76.98       07698       HYPERBARIC OXYGEN THERAPY       0       0       0       76.98         76.99       07699       LITHOTRIPSY       0       0       0       76.98       76.99         00       09000       CLINIC       COST CENTERS       0       0       0       90.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       0       92.00		0	0		0		
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73.00         76.97       07697       CARDI AC REHABILI 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       76.98         00       09000       CLI NI C       0       0       0       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00		0	0		0		
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       76.97         76.98       07699       LITHOTRIPSY       0       0       0       76.98         07699       LITHOTRIPSY       0       0       0       76.98         00TPATIENT SERVICE COST CENTERS       0       0       0       76.99         00TOPATIENT SERVICE COST CENTERS       0       0       0       90.00         90.00       09000       CLINIC       0       0       90.00         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0       0       0       92.00		0	0		0		
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         76.97       07697       CARDI AC REHABILITATION       0       0       0         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       76.99         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       76.99         90.00       09000       CLI NI C       0       0       0       90.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
76.97       07697       CARDI AC REHABILITATION       0       0       0       76.97         76.98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       76.98         76.99       07699       LI THOTRI PSY       0       0       0       76.99         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       90.00         90.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00		0	0		0		
76. 98       07698       HYPERBARI C 0XYGEN THERAPY       0       0       0       76. 98         76. 99       07699       L1 THOTRI PSY       0       0       0       76. 99         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       90. 00         90. 00       09000       CLI NI C       0       0       0       90. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 99         07699         LI THOTRI PSY         0         0         76. 99           OUTPATI ENT SERVICE COST CENTERS         0         0         0         90. 00           90. 00         09000         CLI NI C         0         0         90. 00           92. 00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         92. 00	76. 97 07697 CARDIAC REHABILITATION	0	C		0		76.97
OUTPATI ENT_SERVICE_COST_CENTERS           90. 00         09000         CLINIC         0         0         90. 00           92. 00         09200         0BSERVATI ON_BEDS_(NON-DI STINCT_PART         0         0         0         92. 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0		76.98
90. 00         09000         CLINIC         0         0         90. 00           92. 00         09200         0BSERVATION         BEDS (NON-DISTINCT PART         0         0         0         92. 00	76. 99 07699 LI THOTRI PSY	0	C		0		76.99
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00							
		0	C		0		
200.00          Total (lines 50-199)         0         0         200.00		0	0		0		
	200.00   Total (lines 50-199)	0	C		0		200.00

Health Financial Systems C	RTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016		
	1	Titl	e XIX	Hospi tal	PPS	
			Charges	_	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.10(000			a		
50. 00 05000 OPERATI NG ROOM	0. 106928			0 346, 718		
53. 00 05300 ANESTHESI OLOGY	0. 052916	0		0 27, 901	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 179531	0		0 7,659		
58. 00 05800 MRI	0. 091005	0		0 34, 353		
60. 00 06000 LABORATORY	0. 384331	0		0 1, 829		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 260507	0		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. 165009			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 310366			0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 048190	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 130674	0		0 19, 984	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 254811	0		0 56, 877	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 156101	0		0 20, 639	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 493876	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	1	0 515, 960	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 515, 960	0	202.00

Health Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 6/28/2017 9:	epared: 42 am
		Titl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	-	1	1			
50.00 05000 OPERATI NG ROOM	0	37, 074	1			50.00
53. 00 05300 ANESTHESI OLOGY	0	1, 476				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 375				54.00
58. 00 05800 MRI	0	3, 126				58.00
60. 00 06000 LABORATORY	0	703				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 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	2, 611				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 493				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 222				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		•			76.99
OUTPATIENT SERVICE COST CENTERS	-	-	1			-
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	64, 080				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0.,000				201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	64, 080				202.00
		,	1			1-02.00

	Financial Systems ORTHOPAEDIC HOSPT		In Lie	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016		pared:
		Title XVIII	Hospi tal	6/28/2017 9:4 PPS	2 am
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		5, 860	1.00
2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		siveta naom dava	5, 860	
3.00	do not complete this line.	ays). If you have only pr	Tvate room days,	0	3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	5 /	or 21 of the cost	5, 494 0	
5.00	reporting period	Join days) through Decembe	er si or the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private roo	n davs) after December '	al of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	5		-	
9.00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	843	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	5,7		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	IX only (including privat	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)		-	0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 d	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			6, 563, 862	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 10^{-1}$ x line 17)	per 31 of the cost report	ting period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)		, por ou (1110 o		
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 6, 563, 862	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		 		
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	narges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	1
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lino 22)(soo instru	stions)	0.00	1
34.00 35.00	Average per diem private room cost differential (line 34 x li		5.1.0137	0.00 0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	1
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 563, 862	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.				
	Adjusted general inpatient routine service cost per diem (see	-		1, 120. 11	
	Program general inpatient routine service cost (line 9 x line Medically percessary private room cost applicable to the Program	-		944, 253	
40. 00 41. 00	Medically necessary private room cost applicable to the Program of the Program general inpatient routine service cost (line 34	. ,		0 944, 253	
		/	I	, 200	

INPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0167	Period: From 01/01/2016	Worksheet D-1	1
					To 12/31/2016		
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	-
. 00	NURSERY (title V & XIX only)		2100	0.00		0100	42.
	Intensive Care Type Inpatient Hospital Units	I				l	
. 00	INTENSIVE CARE UNIT						43.
. 00 . 00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44.
	SURGICAL INTENSIVE CARE UNIT						40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	Dragram inpatient anaillen, convice cost (W/	at D 2 agl 2	line 200)			1.00	10
. 00 . 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ns)		11, 234, 083 12, 178, 336	
00	PASS THROUGH COST ADJUSTMENTS			113)		12, 170, 000	1
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sur	n of Parts I and	66, 589	50
~~						000 54/	-
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (Tr	OM WKST. D, S	sum of Parts II	220, 516	51
. 00	Total Program excludable cost (sum of lines !	50 and 51)				287, 105	5 52
. 00	Total Program inpatient operating cost exclude		lated, non-phy	sician anesth	netist, and	11, 891, 231	
	medical education costs (line 49 minus line !	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	C	57
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	ending 1996, i	pdated and co	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	C	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	f the target		
2. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	n period (See	0	65
. 00	instructions) (title XVIII only)	ts after Decemb		οστιεροιτιή	j period (see		00
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	I only). For	C	66
	CAH (see instructions)			<b>.</b>			
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	f the cost re	eporting period	C	67
8. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period		68
	(line 13 x line 20)				511		
. 00	Total title V or XIX swing-bed NF inpatient	```		· · ·		0	) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili		•		<u> </u>		70
. 00	Adjusted general inpatient routine service co				1		71
. 00	Program routine service cost (line 9 x line			_,			72
. 00	Medically necessary private room cost application						73
. 00	Total Program general inpatient routine servi	•					74
. 00	Capital-related cost allocated to inpatient ( 26, line 45)	routine service	COSTS (TFOM W	Orksneet B, F	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
. 00	Inpatient routine service cost (line 74 minus	,					78
00	Aggregate charges to beneficiaries for excess				us lino 70)		80
. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit				143 11118 /7)		80
. 00	Inpatient routine service cost per drem rim		)				82
. 00	Reasonable inpatient routine service costs (		•				83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i ougri 85)			1	86
. 00	Total observation bed days (see instructions)					366	5 87
	Adjusted general inpatient routine cost per o		line 2)			1, 120. 11	
3. 00	Observation bed cost (line 87 x line 88) (see					409, 960	

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	462, 901	6, 563, 862	0. 07052	3 409, 960	28, 912	90.00
91.00 Nursing School cost	0	6, 563, 862	0.00000	0 409, 960	0	91.00
92.00 Allied health cost	0	6, 563, 862	0.00000	0 409, 960	0	92.00
93.00 All other Medical Education	0	6, 563, 862	0.00000	0 409, 960	0	93.00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016		
		Title XIX	Hospi tal	6/28/2017 9:42 PPS	2 am
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
I. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	c oveluding newborn)		5, 860	1.00
2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			5,860	
3.00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3.00
1.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	aveb ba		5, 494	4.0
5. 00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	5, 494	5.0
~~	reporting period				
b. 00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.0
. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	~ 31 of the cost	0	7.0
	reporting period	m dava) aftar Daaambar (	1 of the post	0	
3. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	in days) after beceniber .	si of the cost	0	8.0
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	256	9.0
0.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private u	coom days)	0	10.0
0.00	through December 31 of the cost reporting period (see instruc-		com days)	0	10.0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.0
2.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		te room davs)	0	12.0
	through December 31 of the cost reporting period	5 . 5 .	5 /		
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13.0
4.00	Medically necessary private room days applicable to the Progra			0	14.0
5.00	Total nursery days (title V or XIX only)		•	0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 0
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (	of the cost	0.00	17.0
0 00	reporting period	an aftar December 21 of	the east	0.00	10.0
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es alter December 31 01	the cost	0.00	18.0
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	0.00	19.0
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of <sup>.</sup>	the cost	0, 00	20.0
	reporting period				
21.00 22.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December	·	ting pariod (lina	6, 563, 862 0	
22.00	5 x line 17)	el si ul the cust repui	ting period (inte	0	22.0
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23. 0
24.00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24.0
	7 x line 19)	•	51 (		
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.0
26.00	x line 20) Total swing-bed cost (see instructions)			0	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 563, 862	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bea	d and observation bed c	narges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		iai ges)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 ·	÷line 28)		0.00000	31.0
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.0
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)				33.0
4.00	Average per diem private room charge differential (line 32 min		ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x lin	ne 31)			35. C
6.00	Private room cost differential adjustment (line 3 x line 35)	and private reem east -	fforontial (lis-	6 562 962	36.0
7.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	anu private room cost di	inerential (IINe	6, 563, 862	37.0
	PART I I - HOSPITÁL AND SUBPROVIDERS ONLY				
0 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 100 11	20 0
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		1, 120. 11 286, 748	
19 NN	IT OUT AN ACTOR AT THE ATTACK TOULTHE SETVICE COST (TITLE 7 & TITLE	,		200, 740	1 37.0
39.00 10.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.0

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016		
						6/28/2017 9:4	
	Cost Center Description	Total Inpatient Cost	Total	e XIX Average Per Diem (col. 1 col. 2)		PPS Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)						42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43
00	CORONARY CARE UNI T						44
00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	·					1.00	
00	Program inpatient ancillary service cost (Wks					77, 133	
00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ons)		363, 881	49
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sur	of Parts L and	20, 221	50
00						20,22	
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	1, 449	9 51
00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				21, 670	52
. 00	Total Program inpatient operating cost exclusion		lated, non-phy	sician anestr	etist, and	342, 211	
	medical education costs (line 49 minus line						
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0. 00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	C	
00	Bonus payment (see instructions)					C	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	updated and co	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report up	dated by the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of line				the amount by	0,00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see i	instructions)				C	) 62
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymu	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	(					
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to ofter Decemb	or 21 of the c	act conarting	partial (Saa	c	) 65
00	instructions) (title XVIII only)	ts after Decemb		υστ τεροιτιτή	j perioù (see	(	00
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	I only). For	C	66
~ ~	CAH (see instructions)			e			
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	C	) 67
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	ortina period	C	68
	(line 13 x line 20)				5 1		
. 00	Total title V or XIX swing-bed NF inpatient			,			) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line	71)					72
00	Medically necessary private room cost application						73
. 00 . 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II column		74
. 00	26, line 45)	Satine Selvice		IN NOTROLEUL D, 1	art II, CULUMMI		1 '3
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess	,	rovi dor roccra				78
00	Total Program routine service costs for compa	• •		· · · ·	us line 79)		80
00	Inpatient routine service cost per diem limit			(			81
00	Inpatient routine service cost limitation (1	ine 9 x line 81	· .				82
00	Reasonable inpatient routine service costs (		s)				83
00 00	Program inpatient ancillary services (see in:		nc)				84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
55	PART IV - COMPUTATION OF OBSERVATION BED PASS		. sag. 00)				
						366	1 07
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per o					1, 120. 11	

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	462, 901	6, 563, 862	0. 07052	3 409, 960	28, 912	90.00
91.00 Nursing School cost	0	6, 563, 862	0.00000	0 409, 960	0	91.00
92.00 Allied health cost	0	6, 563, 862	0.00000	0 409, 960	0	92.00
93.00 All other Medical Education	0	6, 563, 862	0.00000	0 409, 960	0	93.00

Health Financial Systems ORT	THOPAEDIC HOSPT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider CC	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 6/28/2017 9:4	pared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			2, 660, 858		30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 10692			
53. 00 05300 ANESTHESI OLOGY		0. 0529			
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1795:			
58. 00 05800 MRI		0.09100			
60. 00 06000 LABORATORY		0. 38433			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 26050	-	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65.00 06500 RESPI RATORY THERAPY		0. 16500			
66. 00 06600 PHYSI CAL THERAPY		0. 3103			
69. 00 06900 ELECTROCARDI OLOGY		0. 04819		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 1306			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2548			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 15610			
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	1 . 0 0
76. 99 07699 LI THOTRI PSY		0.0000	0 00	0	76.99
OUTPATIENT SERVICE COST CENTERS				-	
90. 00 09000 CLINIC		0.0000		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 4938		0	1 2.00
200.00 Total (sum of lines 50-94 and 96-98)			62, 701, 853		
201.00 Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			62, 701, 853		202.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 6/28/2017 9:4	pared:
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			17, 043		30.00
ANCILLARY SERVICE COST CENTERS			-		
50.00 05000 OPERATI NG ROOM		0. 10692			50.00
53. 00 05300 ANESTHESI OLOGY		0. 05291		820	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17953		646	
58. 00 05800 MRI		0. 09100		0	58.00
60. 00 06000 LABORATORY		0. 38433		2, 136	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 26050		0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY		0. 16500	)9 1, 603	265	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 31036	6 10, 015	3, 108	
69. 00 06900 ELECTROCARDI OLOGY		0. 04819		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 13067			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25481			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 15610	01 25, 318	3, 952	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	76. 98
76. 99 07699 LI THOTRI PSY		0.0000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 49387	76 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)			422, 058	77, 133	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			422, 058		202.00

ALCUL	Financial Systems ORTHOPAEDIC HOSPT. ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 6/28/2017 9:4	pared:	
		Title XVIII	Hospi tal	PPS	1	
				1.00		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00		
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 7, 843, 910		
02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	2, 764, 932	1. 02	
03	instructions) DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	for discharges occurring	prior to October	0	1. 03	
04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1. 04	
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			30, 482 0	1	
02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0		
00	Managed Care Simulated Payments			7, 766, 389	3.00	
00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment			36.00	4.00	
00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	1 5		0.00		
00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)			0.00		
00	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified	,		0.00 0.00		
00	If the cost report straddles July 1, 2011 then see instructio Adjustment (increase or decrease) to the FTE count for allopa	ins.	, , , , , , , , , , , , , , , , , , , ,	0.00		
00	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	0.0	
01	The amount of increase if the hospital was awarded FTE cap sl the cost report straddles July 1, 2011, see instructions.	ots under section 5503 of	of the ACA. If	0.00	8.0	
02						
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.00	
0. 00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recom	-ds		10.00	
1.00	FTE count for residents in dental and podiatric programs.				11.00	
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.				12.0	
4. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,		14.0	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15.0	
5.00	Adjustment for residents in initial years of the program			0.00	16.0	
	Adjustment for residents displaced by program or hospital clo	sure			17.0	
	Adjusted rolling average FTE count	<b>`</b>			18.0	
9.00 0.00	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	·).		0. 000000 0. 000000		
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		
	IME payment adjustment (see instructions)			0	1	
	IME payment adjustment - Managed Care (see instructions)			0	22.0	
3. 00	Indirect Medical Education Adjustment for the Add-on for Sect Number of additional allopathic and osteopathic IME FTE resid		Sec. 412.105	0.00	23.0	
4. 00	(f)(1)(iv)(C) IME FTE Resident Count Over Cap (see instructions)			0.00	24.0	
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00		
5.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0	
7.00	IME payments adjustment factor. (see instructions)			0.00000	27.0	
	IME add-on adjustment amount (see instructions)			0		
3. 01	IME add-on adjustment amount - Managed Care (see instructions	.)		0		
9.00	Total IME payment ( sum of lines 22 and 28)			0		
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Dispreparti epate Share Adjustment	11)		0	29.0	
D. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient davs (see instrum	tions)	0.00	30.0	
1.00	Percentage of Medicaid patient days (see instructions)	actent days (see fiistiud			30.0	
	Sum of Lines 30 and 31				32.0	
3.00	Allowable disproportionate share percentage (see instructions	5)			33.0	
	Disproportionate share adjustment (see instructions)				34.0	

5.00 5.01 5.02 4.5.02 5.03 6.03 1 6.00 1	ncompensated Care Adjustment	Title XVIII	From 01/01/2016 To 12/31/2016 Hospi tal		
5.00 5.01 5.02 4.5.02 5.03 6.03 1 6.00 1		Title XVIII	Hospi tal	6/28/2017 9:42	
5.00 5.01 5.02 4.5.02 5.03 6.03 1 6.00 1				PPS	<u>2 am</u>
5.00 5.01 5.02 4.5.02 5.03 6.03 1 6.00 1			Prior to 10/1		
5.00 5.01 5.02 4.5.02 5.03 6.03 1 6.00 1			1.00	2.00	
5.01 F 5.02 F 5.03 F 6.00 1					
5.02 H 5.03 F 6.00 T	otal uncompensated care amount (see instructions)			5, 977, 483, 147	
5.03 F 6.00 T	actor 3 (see instructions)		0.000004054		
5.03 F	lospital uncompensated care payment (If line 34 is zero, e see instructions)	nter zero on this line)	0	0	35.0
6.00 1	ro rata share of the hospital uncompensated care payment a	mount (see instructions)	0	0	35.0
	otal uncompensated care (sum of columns 1 and 2 on line 35		0		36.0
	dditional payment for high percentage of ESRD beneficiary				
	otal Medicare discharges on Worksheet S-3, Part I excludin		0		40.0
e	52, 682, 683, 684 and 685 (see instructions)				
	otal ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.0
	nstructions)				
	otal ESRD Medicare covered and paid discharges excluding M	IS-DRGS 652, 682, 683, 684	0		41.0
	n 685. (see instructions) ivide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.0
	otal Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42.0
	nstructions)	002, 000, 001 an 000. (300	0		10.0
1	atio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0.000000		44.0
c	lays)	5			
	verage weekly cost for dialysis treatments (see instructio		0.00		45.0
	otal additional payment (line 45 times line 44 times line	41.01)	0		46.0
	ubtotal (see instructions)		10, 639, 324		47.0
	lospital specific payments (to be completed by SCH and MDH, nlv. (see instructions)	small rural nospitals	0		48.0
				Amount	
				1.00	
9.00 1	otal payment for inpatient operating costs (see instructio	ins)		10, 639, 324	49.0
0. 00 F	ayment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		846, 110	50.0
1.00 E	xception payment for inpatient program capital (Wkst. L, P	t. III, see instructions)		0	51.C
	irect graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	
	lursing and Allied Health Managed Care payment			0	
	pecial add-on payments for new technologies			0	
	slet isolation add-on payment et organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	60)		0	
	ost of physicians' services in a teaching hospital (see in			0	
	outine service other pass through costs (from Wkst. D, Pt.		rough 35).	Ő	
	ncillary service other pass through costs from Wkst. D, Pt			0	
	otal (sum of amounts on lines 49 through 58)			11, 485, 434	59.0
	rimary payer payments			0	60.0
	otal amount payable for program beneficiaries (line 59 min	us line 60)		11, 485, 434	
1	eductibles billed to program beneficiaries			1, 059, 940	1
	oinsurance billed to program beneficiaries			0	
	llowable bad debts (see instructions)			2, 434	
	djusted reimbursable bad debts (see instructions)			1, 582	
	llowable bad debts for dual eligible beneficiaries (see in	ISTRUCTIONS)		2,434	
	ubtotal (line 61 plus line 65 minus lines 62 and 63) redits received from manufacturers for replaced devices fo	r applicable to MS_DPCs (s	e instructions)	10, 427, 076 0	1
1	utlier payments reconciliation (sum of lines 93, 95 and 96			0	
1	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		· /	0	
	URAL DEMONSTRATION PROJECT			0	
	CH or MDH volume decrease adjustment			0	
	ioneer ACO demonstration payment adjustment amount (see in	structions)		0	1
	SP bonus payment HVBP adjustment amount (see instructions)			0	70.9
	SP bonus payment HRR adjustment amount (see instructions)			0	
	undled Model 1 discount amount (see instructions)			0	
	VBP payment adjustment amount (see instructions)			115, 092	
	IRR adjustment amount (see instructions) Necovery of accelerated depreciation			0	70.9

	Financial Systems ORTHOPAEDIC HOSPT				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Prep 6/28/2017 9:42	
		Title	XVIII	Hospi tal	PPS	
			FFY	′ (уууу)	Amount	
				0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.97
70.00	the corresponding federal year for the period ending on or at	rter 10/1)				70.00
70.98	Low Volume Payment-3				0	70.98
70.99	HAC adjustment amount (see instructions)	(0, 0, 70)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			10, 542, 168	
71.01	Sequestration adjustment (see instructions)				210, 843	
72.00	Interim payments				10, 329, 772	
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72					74.00
75.00	Protested amounts (nonallowable cost report items) in accorda	ance with			0	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				-	
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see inst				0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see inst				0.00	
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 instruc	ctions)			0	96.00
				Prior to 10/1		
				1.00	2.00	
100.00	HSP Bonus Payment Amount					100 00
100.00	HSP bonus amount (see instructions)			0	0	100.00
4.0.4 .0.0	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.0000000000	101 00
	HVBP adjustment factor (see instructions)	>		0.000000000	0.000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102.00
400.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100 00
	HRR adjustment factor (see instructions)	`		0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions	5)		0	0	104.00

CALCOUNTION OF REIMBURSEMENT SETTLEMENT         Provider CON: 15-0167         Provider CON: 15-0167         Provider CON: 15-0167           Number Construction         Ittle XVIII         Itsplitzion           Number Construction         Itsplitzion         Itsplitzion           Number Construction         Itsplitzion         Itsplitzion         Itsplitzion           Number Construction         Itsplitzion         Itsplitzion	eu of Form CMS-2 Worksheet E	1052-1
PART B - MEDICAL AND OTHER HEALTH SERVICES         1.00       Medical and other services (see Instructions)         2.00       Medical and other services (real instructions)         2.00       PSS payments         2.00       Intervices instructions)         2.00       Difference         2.00       Intervices instructions)         2.00       Difference         2.00       New Section         2.01       New Section         2.02       New Section         2.03       New Section         2.04       New Section         2.05       New Section         2.06       New Section         2.07       New Section         2.08       New Section         2.09       New Section         2.00       New Section         2.01       New Section         2.02       New Section	6 Part B 6 Date/Time Prep	pared
<ul> <li>Medical and other services (see instructions)</li> <li>Medical and other services reinbursed under OPPS (see instructions)</li> <li>PPS payments</li> <li>Outline payment (see instructions)</li> <li>Enter the hospital specific payment to cost ratio (see instructions)</li> <li>Enter the hospital specific payment (see instructions)</li> <li>Iransitional cort dor payment (see instructions)</li> <li>Iransitional cort dor payment (see instructions)</li> <li>Iransitional cort of payment (see instructions)</li> <li>Iransitional cort of the payment (see instructions)</li> <li>Iransitional cort of physicians' services in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (see instructions)</li> <li>Itasser of cost or charges (from Origon Inters 3, 4, and 9)</li> <li>Itasser of cost or charges (from West, 14, and 14, and 14, for CAH, see instructions)</li> <li>Itasser of cost or charges (in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (from CAH, see instructions)</li> <li>Itasser of cost or charges (from CAH, see instructions)</li> <li>Itasser o</li></ul>	6/28/2017 9: 42 PPS	<u>2 am</u>
<ul> <li>Medical and other services (see instructions)</li> <li>Medical and other services reinbursed under OPPS (see instructions)</li> <li>PPS payments</li> <li>Outline payment (see instructions)</li> <li>Enter the hospital specific payment to cost ratio (see instructions)</li> <li>Enter the hospital specific payment (see instructions)</li> <li>Iransitional cort dor payment (see instructions)</li> <li>Iransitional cort dor payment (see instructions)</li> <li>Iransitional cort of payment (see instructions)</li> <li>Iransitional cort of the payment (see instructions)</li> <li>Iransitional cort of physicians' services in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (see instructions)</li> <li>Itasser of cost or charges (from Origon Inters 3, 4, and 9)</li> <li>Itasser of cost or charges (from West, 14, and 14, and 14, for CAH, see instructions)</li> <li>Itasser of cost or charges (in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (in a teaching hospital (see instructions)</li> <li>Itasser of cost or charges (from CAH, see instructions)</li> <li>Itasser of cost or charges (from CAH, see instructions)</li> <li>Itasser o</li></ul>	1.00	
<ul> <li>Medical and other services reinbursed under OPPS (see instructions)</li> <li>Medical and other services reinbursed under OPPS (see instructions)</li> <li>OUTI ier payment (see instructions)</li> <li>Direct the hospital specific payment to cost ratio (see instructions)</li> <li>Direct the hospital specific payment (see instructions)</li> <li>Anound acquisitions</li> <li>Organ acquisitions</li> <li>Organ acquisitions</li> <li>Organ acquisitions</li> <li>Organ acquisitions</li> <li>Organ acquisitions and the services of the set instructions)</li> <li>Organ acquisitions</li> <li>Organ acquisition charges (from Wkst. D. Pt. IV, col. 13, line 200</li> <li>Organ acquisition charges (from Wkst. D. 4, Pt. III, col. 4, line 60)</li> <li>Organ acquisition charges (from Wkst. D. 4, Pt. III, col. 4, line 60)</li> <li>Organ acquisition charges (from Wkst. D. 4, Pt. III, col. 4, line 60)</li> <li>Organ acquisition charges (from Wkst. D. 4, Pt. III, col. 4, line 60)</li> <li>Organ acquisition charges (from the services on a charge basis in had such payment bere made in accordance with 42 CFR 5413 (see)</li> <li>Ratio of line 15 to line 16 (not to exceed 1.000000)</li> <li>Otati customary charges (see instructions)</li> <li>Descess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>Descess of customary charges (see instructions)</li> <li>Descess of customary charges (see instructions)</li> <li>Descess of customary charges (see instructions)</li> <li>Deductibles and coinsurance (for CAH, see instructions)</li> <li>Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>Direct graduate medical education pay</li></ul>	1.00	
<ul> <li>3.00 PPS payments</li> <li>4.00 puttler payment (see instructions)</li> <li>5.00 Enter the hospital specific payment to cost ratio (see instructions)</li> <li>5.00 Line 2 times line 5</li> <li>5.00 Transitional corridor payment (see instructions)</li> <li>4.01 Transitional corridor payment (see instructions)</li> <li>4.01 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.02 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.03 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.04 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.04 Ancillary service otherges</li> <li>4.05 Ancillary service otherges</li> <li>4.06 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.07 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.08 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.00 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.00 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.00 Ancillary service otherges (sum of lines 12 and 13)</li> <li>4.00 Ancillary status that would have been realized from payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)</li> <li>4.00 Excess of customery charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>4.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 13) (see instructions)</li> <li>4.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 13) (see instructions)</li> <li>4.00 Excess of reasonable cost (complete only if line 11 exceeds line 13)</li> <li>4.00 Excess of reasonable cost (complete only if line 11 exceeds line 13)</li> <li>4.00 Excess of reasonable cost (complete only if line 18 exceeds line 14)</li> <li>4.00 Excess of reasonable cost (completing basend on lines</li></ul>	0	1.0
<ul> <li>4.00 Outlier payment (see instructions)</li> <li>4.00 Dutlier payment (see instructions)</li> <li>4.00 Dutlier payment (see instructions)</li> <li>4.00 Dutlier payment (see instructions)</li> <li>4.00 Dirac payment (see instructions)</li> <li>4.00 Anciliary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.00 Organ acquisitions</li> <li>4.00 Total cost (sum of lines 1 and 10) (see instructions)</li> <li>4.00 Anciliary service other gass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>4.00 Total cost (sum of lines 1 and 10) (see instructions)</li> <li>4.00 Total cost (sum of lines 1 and 10) (see instructions)</li> <li>4.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>4.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>4.00 Anciliary service some set (sum of lines 12 and 13)</li> <li>4.00 Anciliary service charges (sum of lines 12 and 13)</li> <li>4.00 Angengate amount actually collected from patients liable for payment for services on a charge basis in a such payment been made in accordance with 42 CFR \$413.13(e)</li> <li>4.00 Total customery charges (see instructions)</li> <li>4.00 Total customery charges (line 11 minus line 20) (for CAH see instructions)</li> <li>4.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>4.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>4.00 Deductibles and coinsurance relating to amount on line 25 and 26 plus the sum of lines 22 and 23 (see instructions)</li> <li>4.00 Subtotal (sum of l</li></ul>	1,008,209	2.0
<ul> <li>5.00 Enter the fospital specific payment to cost ratio (see instructions)</li> <li>6.0 Line 2 times line 5</li> <li>7.00 Sum of line 3 plus line 4 divided by line 6</li> <li>8.00 Transitional corridor payment (see instructions)</li> <li>7.00 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>7.00 Organ acquisitions</li> <li>7.01 Total cost (sum of lines 1 and 10) (see instructions)</li> <li>7.00 Ancillary service other pass through costs from Wkst. D. 4. It. V, col. 13, line 200</li> <li>7.00 Ancillary service other pass through costs from Wkst. D. 4. Pt. 111, col. 4, line 69)</li> <li>7.01 Total cost (sum of lines 12 and 13)</li> <li>7.00 Ancillary service otherges (sum of lines 12 and 13)</li> <li>7.00 Ancillary services on a charge same file file file for payment for services on a charge basis in a cost payment been made in accordance with 42 CFR \$413.13(e)</li> <li>7.00 Excess of customery charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>7.00 Excess of customery charges (sum of lines 2.4, 8 and 9)</li> <li>7.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (from Wkst. E-4, line 50)</li> <li>7.00 Excess of reasonable cost over customary charges (com of lines 2.2 and 2.3) (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (see instructions)</li> <li>7.00 Excess of reasonable cost over customary charges (see instructions)</li> <li>7.00 Excess of reasonable cost over (root Kst. E-4, line 50)&lt;</li></ul>	1, 734, 629 24, 928	3. C
<ul> <li>6.00 Line 2 times jine 5</li> <li>6.00 Sum of line 3 plus line 4 divided by line 6</li> <li>7.00 Sum of line 3 plus line 4 divided by line 6</li> <li>7.00 Anciliary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200</li> <li>0.01 Order cost (sum of lines 1 and 10) (see instructions)</li> <li>7.00 Marching Service Charges</li> <li>7.00 Anciliary service charges (sum of lines 12 and 13)</li> <li>7.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>7.01 Total reasonable charges (sum of lines 12 and 13)</li> <li>7.02 Aggregate amount actually collected from patients liable for payment for services on a charge basis in a dusch payment been made in accordance with 42 CFR §413.13(e)</li> <li>7.00 Ratio of line 15 to line 16 (not to exceed 1.000000)</li> <li>7.00 Ratio of line 51 to line 16 (not to exceed 1.000000)</li> <li>7.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)</li> <li>7.00 Deductions) charges (line 11 minus line 20) (for CAH see instructions)</li> <li>7.00 Deductibles and colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.00 Deductibles and colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.00 Deductibles and colinsurance (from Kkst. E-4, line 36)</li> <li>7.00 Deductibles and colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.00 Deductibles and Colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.00 Distructibles and Colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.01 Subtotal (lines 21 and 24 minus the sum of lines 22 and 23] (see linstructions)</li> <li>7.01 Subtotal (lines 30 from sets (see instructions)</li> <li>7.02 Subtotal (see linstructions)</li> <li>7.03 Subtotal (see linstructions)</li> <li>7.04 Deductibles and colorsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>7.05 Subtotal (see linstructions)</li> <li>7.05</li></ul>	0.000	5.0
<ul> <li>8.00 Transitional corridor payment (see instructions)</li> <li>9.0 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13. Line 200</li> <li>9.0 Organ acquisitions</li> <li>9.0 Total cost (sum of lines 1 and 10) (see instructions)</li> <li>9.0 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Line 69)</li> <li>12.00 Ancillary service charges</li> <li>12.00 Ancillary service scale (sum of lines 12 and 13)</li> <li>9.0 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Line 69)</li> <li>13.00 Organ acquisition charges (from Wst. D-4, Pt. III, col. 4, Line 69)</li> <li>14.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e)</li> <li>15.00 Agounts that would have been reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>15.00 Excess of customary charges (see instructions)</li> <li>10.00 Excess of customary charges (see instructions)</li> <li>10.01 Excess of customary charges (see instructions)</li> <li>10.02 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>10.01 Datal prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>10.02 Computations (service) and the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>20.0 Deductibles and colinsurance (for CAH, see instructions)</li> <li>20.0 Deductibles and colinsurance (from Kkst. E-4, line 36)</li> <li>20.0 Direct graduate medical education payments (from Wst. E-4, line 36)</li> <li>20.0 Direct graduate medical education costs (from Nst. E-4, line 36)</li> <li>20.0 Direct graduate medical education costs (from Nst. E-4, line 36)</li> <li>20.0 Dived fullows for Using Size (See Instructions)</li> <li>21.0 Divested real time 30 main the 31)</li> <li>22.0 Divested real times for Dives 25 Process (see instructions)</li> <li>23.0 Organ Addebts (see instructions)</li> <li>24.0 Ordi</li></ul>	0	6.0
<ul> <li>9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200</li> <li>9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200</li> <li>9.00 Ancillary service charges</li> <li>9.00 Ancillary service charges</li> <li>9.00 Ancillary service charges (from Wkst. D-4, Pt. 111, col. 4, line 69)</li> <li>10.01 Total reasonable charges (gum of lines 12 and 13)</li> <li>Customary charges</li> <li>10.03 Ancounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$431.31(e)</li> <li>10.04 Agengeste amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$431.31(e)</li> <li>10.00 Total customary charges (see instructions)</li> <li>10.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>10.01 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions)</li> <li>10.01 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions)</li> <li>11.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions)</li> <li>12.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>12.00 Deductibles and colinsurance (for CAH, see instructions)</li> <li>12.00 Deductibles and colinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>23.00 Cost of physicians' Services in a teaching hospital (see instructions)</li> <li>24.00 Deductibles and colinsurance (from Wkst. E-4, line 36)</li> <li>25.00 Deductibles and colinsurance (from Wkst. E-4, line 36)</li> <li>26.00 Destrate (see instructions)</li> <li>27.01 Deductibles and colinsurance (from Wkst. E-4, line 36)</li> <li>28.00 Corinet medical education coxits (from Wkst. E-4, line</li></ul>	0.00	
<ul> <li>10.00 Organ acquisitions</li> <li>10.01 Ordal cost (sum of lines 1 and 10) (see instructions)</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable charges</li> <li>12.00 Ancillary service charges (from Wkst. D-4, Pt. 111, col. 4, line 69)</li> <li>14.00 Organ acquisition charges (from the transmitted of t</li></ul>	0	8.0
<ul> <li>11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF ELESSER OF COST OR CHARGES Reasonable charges 12.00 Anchilary service charges 13.00 Organ acquisition charges (sum of lines 12 and 13) Customary charges 13.00 Agrapt reasonable charges (sum of lines 12 and 13) 13.00 Agrapt reasonable charges (sum of lines 12 and 13) 13.00 Agrapt reasonable charges (sum of lines 12 and 13) 13.00 Agrapt reasonable charges (sum of lines 12 and 13) 13.00 Agrapt reasonable charges (sum of lines 12 and 13) 13.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 13.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 14.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see instructions) 14.00 Total customary charges (line 11 minus line 20) (for CAH see instructions) 15.00 Excess of cost or charges (line 11 minus line 20) (for CAH see instructions) 15.00 Cost of physicians' services in a teaching hospital (see instructions) 16.00 Total prospective payment (sum of lines 3.4, 8 and 9) 17.00 Excess and colonsurance (for CAH, see instructions) 17.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 17.00 Deductibles and colonsurance (from Wkst. E-4, line 30) 10.00 Direct graduate addical education payments (from Wkst. E-4, line 30) 10.01 Printing (Lines 21 through 29) 11.00 Printing (ELINEURSEXTUNCTIONS) 13.00 Composite rate ESRO (from Wkst. I-5, line 11) 14.00Male Eadd DeBTS FOR PROFESSIONAL SERVICES) 13.00 Composite rate ESRO (from Wkst. E-4, line 30) 13.00 Adj usted reinbursable bad debts (see instructions) 13.00 Adj usted reinbursable bad debts (see instructions) 13.00 Adj usted reinbursable Eadd DEBTS FOR PROFESSIONAL SERVICES) 13.00 Composite rate ESRO (from Wkst. I-5, line 11) 14.00Male Eadd DEBTS for PROFESSIONAL SERVICES) 15.00 Adj usted reinbursable EAD DEBTS FOR PROFESSIONAL SERVICES) 16.00 Adj usted reinbursable</li></ul>	0	9. C
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<ul> <li>12.00 Ancillary service charges</li> <li>13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)</li> <li>14.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>Customary charges</li> <li>15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.00000)</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions)</li> <li>19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>22.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total coll sustance (For CAH, see instructions)</li> <li>25.00 Deductibles and coinsurance (For CAH, see instructions)</li> <li>26.00 Deductibles and Coinsurance (For Wkst. E-4, line 50)</li> <li>27.00 Subtata (sum of lines 21 and 24 minus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 Direct medical education costs (from Wkst. E-4, line 50)</li> <li>20.00 Subtata (sum of lines 21 frough 29)</li> <li>21.00 Subtata (sum of lines 21 frough 29)</li> <li>21.00 Subtata (sum education costs (from RPRESSIONAL SERVICES)</li> <li>22.00 Subtata (sum education costs (from Wkst. E-4, line 50)</li> <li>23.00 Direct medical education costs (from Wkst. E-4, line 50)</li> <li>24.00 Subtata (sum education costs (from Wkst. E-4, line 50)</li> <li>25.00 Subtata (sum education costs (from Wkst. E-4, line 50)</li> <li>26.00 Subtata (sum education costs (from Wkst. E-5, line 11)</li> <li>27.00 Subtata (sum educati</li></ul>		
<ul> <li>13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)</li> <li>14.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>Customary charges</li> <li>15.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.00000)</li> <li>18.00 Excess of customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>10.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>10.02 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>10.03 Cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>10.04 Interns and residents (see instructions)</li> <li>10.04 Interns and residents (see instructions)</li> <li>10.05 CoMPUTINIO OF REINBURSEMENT SETTLEMENT</li> <li>10.00 Deductibles and colinsurance (for CAH, see instructions)</li> <li>11.00 Deductibles and colinsurance (for CAH, see instructions)</li> <li>12.00 Dester davate medical education payments (from Wkst. E-4, line 50)</li> <li>13.00 Subtotal (sum of lines 27 through 29)</li> <li>13.00 Primary payer payments</li> <li>13.00 Subtotal (une 30 minus line 31)</li> <li>13.00 Adjusted reimbursible bad debts (see instructions)</li> <li>13.00 Adjusted reimbursible bad debts (see instructions)</li> <li>13.00 Allowable bad debts (see instructions)</li> <li>13.00 Allowable bad debts (see instructions)</li> <li>14.00 Allowable bad debts (see instructions)</li> <li>15.00 Adjusted reimbursible bad debts (see instructions)</li> <li>16.00 Allowable bad debts (see instructions)</li> <li>17.00 Subtotal (see instructions)</li> <li>18.00 Allowable bad debts (see instructions)</li> <li>19.00 Allowable bad debts (see instructions)</li></ul>		10.0
<ul> <li>14.00 [Total reasonable charges (sum of lines 12 and 13) Customary charges</li> <li>15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.00000)</li> <li>18.00 [Excess of customary charges (see instructions)</li> <li>19.00 [Excess of customary charges (see instructions)</li> <li>19.00 [Excess of customary charges (see instructions)</li> <li>10.00 [Cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>21.00 [Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>23.00 [Cost of physicians' services in a teaching hospital (see instructions)</li> <li>23.00 [Cost of physicians' services (for CAH, see instructions)</li> <li>24.00 [Cost of physicians' services (for CAH, see instructions)</li> <li>25.00 [Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>26.00 [Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 [Subtal (line 21 and 24 minus the sun of lines 25 and 26) plus the sun of lines 22 and 23] (see instructions)</li> <li>28.00 [Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 [Stotal (sum of lines 27 through 29)</li> <li>31.00 [Computation (Sine Sine Sine Sine Sine Sine Sine Sine</li></ul>		12. C
Customary charges           10:00         Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance wit h4 2 CFR §413.13(e)           17:00         Ratio of line 15 to line 16 (not to exceed 1.000000)           18:00         Total customary charges (see instructions)           10:00         Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)           10:01         Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)           21:00         Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)           21:00         Lesses of customary charges (ine 11 minus line 20) (for CAH see instructions)           22:00         Interns and residents (see instructions)           23:00         Cost of physicians' services in a teaching hospital (see instructions)           24:00         Deductibles and colinsurance (for CAH, see instructions)           25:00         Deductibles and colinsurance (for CAH, see instructions)           27:00         Subtotal (Line 32 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)           20:00         Subtotal (sem of lines 27 through 29)           20:00         Subtotal (see instructions)           31:00         Computing payments		
<ul> <li>16.00 Amounts that would have been realized from patients Hiable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)</li> <li>18.00 Excess of customary charges (see instructions)</li> <li>00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>010 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Exsess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Exsess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>010 Direct paraduate (see instructions)</li> <li>02.00 Deductibles and Coinsurance (for CAH, see instructions)</li> <li>02.00 Deductibles and Coinsurance (for GAH, see instructions)</li> <li>02.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>02.00 Direct graduate medical education payments (from Wkst. E-4, line 36)</li> <li>03.00 Composite at esR0 (from Wkst. 1-5, line 11)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>03.00 Candotal (see instructions)</li> <li>04 Aljowable bad debts (see instructions)</li> <li>05.00 Adjusted reimbursable bad debts (see instructions)</li> <li>05.00 Adjusted reimbursable bad debts (see instructions)</li> <li>06.00 Subtotal (see instructions)</li> <li>07.00 Subtotal (see instructions)</li> <li>08.00 Subtotal (see instructions)</li> <li>09.00 Secore</li></ul>		
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<ul> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.00000)</li> <li>18.00 Total customary charges (see Instructions)</li> <li>19.00 Excess of reasonable cost over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>20.01 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>21.00 Escess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>COMPUTATION OF RETNBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESR0 direct medical education costs (from Wkst. E-4, line 50)</li> <li>29.00 ESR0 direct medical education costs (from Wkst. E-4, line 36)</li> <li>20.00 Subtotal (sum 60 minus line 31)</li> <li>21.00 Adjusted real moust line 31)</li> <li>22.00 Adjusted relimbursable bad debts (see instructions)</li> <li>23.00 Adjusted relimbursable bad debts (see instructions)</li> <li>23.00 Adjusted relimbursable bad debts (see instructions)</li> <li>24.00 Primer ACO demonstration payment dynament (see instructions)</li> <li>25.00 Subtotal (see instructions)</li> <li>26.00 Adjusted relimbursable bad debts (see instructions)</li> <li>27.01 Adjusted relimbursable bad debts (see instructions)</li> <li>28.00 Adjusted relimbursable bad debts (see instructions)</li> <li>29.00 Filer ADJUSTNENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>29.01 Printer or of adjustment adjustment (see instructions)<td>0</td><td>16. C</td></li></ul>	0	16. C
<ul> <li>18:00 Total customary charges (see instructions)</li> <li>19:00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>20:00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>21:00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>22:00 Interns and residents (see instructions)</li> <li>23:00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24:00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25:00 Deductibles and colnsurance (for CAH, see instructions)</li> <li>26:00 Eductibles and colnsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27:00 Subtotal (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28:00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29:00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>20:00 Subtotal (sum of lines 27 through 29)</li> <li>21:00 Primary payer payments</li> <li>20:00 Allowable bad debts (see instructions)</li> <li>20:00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>21:00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>23:00 Composite rate ESRD (from Mst. 1-5, line 11)</li> <li>24:00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>29:00 FSRD (CC reconciliation amount from PSAR</li> <li>29:00 FSRD (ACC reconciliation amount from PSAR</li> <li>29:00 FSRD (ACC REARTED DEPRECIATIONS)</li> <li>20:00 Tentative settlement (see instructions)</li> <li>20:00 Tentative settlement (for contractors use only)</li> <li>20:00 Tentative settlement (for contractors use only)</li> <li>20:00 Tentative settlement (for contractors use only)</li> <li>20:00 Tentative settlement (for contractors use</li></ul>	0. 000000	17 (
<ul> <li>19:00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>20.00 Excess of customary charges over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>25.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Detect graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (line 30 minus line 31)</li> <li>21.00 Allowable bad debts (see instructions)</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Allowable bad debts (see instructions)</li> <li>36.00 Allowable bad debts (see instructions)</li> <li>37.00 Subtotal (sum of lines 27 through 29)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 Allowable bad debts (see instructions)</li> <li>39.00 Allowable bad debts (see instructions)</li> <li>39.00 Allowable bad debts (see instructions)</li> <li>39.90 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.90 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.90 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.90 Free Code demonstration payment (see instructions)</li> <li>39.90 Therative settlement (for contractors use only)</li> <li>30.00 Balance due provider/program (see instructions)</li> &lt;</ul>	0.000000	18.0
<ul> <li>20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> <li>21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>25.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance (for Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE RAD DEBTS (FXCLUE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Allowable bad debts (see instructions)</li> <li>36.00 Allowable bad debts (see instructions)</li> <li>38.00 MSP-LCC reconcliaiton amount from PS&amp;R</li> <li>39.90 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RotOKENV FACELERATED DEPRECIENT)</li> <li>39.99 RotOKENV FACELERATED DEPRECIENT)</li> <li>39.99 RotOKENV FACELERATED DEPRECIENT (SEE INSTRUCTIONS)</li> <li>40.01 Sequestration aguments (see instructions)</li> <li>30.02 Subtotal (see instructions)</li> <li>30.03 Subtotal (see instructions)</li> <li>30.04 Invable bad debts (see instructions)</li> <li>31.05 Adjusted reimbursable bergetiation amount from PS&amp;R</li> <li>32.00 Allowable cost received from manufacturers for replaced devices (see instructions)</li> <li>32.00 ESCHENCELERATED DEPRECIATION</li> <li>32.00 Tentative settlement (f</li></ul>	0	
<ul> <li>instructions)</li> <li>instructions)</li> <li>interns and residents (see instructions)</li> <li>interns and residents (see instructions)</li> <li>Ocst of physicians' services in a teaching hospital (see instructions)</li> <li>Otal prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>COMPUTATION OF RELIMBURSEMENT SETTLEMENT</li> <li>Deductibles and Coinsurance (for CAH, see instructions)</li> <li>Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>O Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>O Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>O Direct graduate medical education costs (from Wkst. E-4, line 36)</li> <li>O Subtotal (sum of lines 27 through 29)</li> <li>O Primary payer payments</li> <li>O Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>O Adjusted reimbursable bad debts (see instructions)</li> <li>O Adjusted reimbursable bad debts (see instructions)</li> <li>O Subtotal (see instructions)</li> <li>O Subtotal (see instructions)</li> <li>O MSP-LCC reconclilation amount from PS&amp;R</li> <li>O Offer ADJUSTINTS (SEE LINSTRUCTIONS) (SPECIFY)</li> <li>Primary Payments</li> <li>Primary Full or full credits received from manufacturers for replaced devices (see instructions)</li> <li>Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, stil.5.</li> <li>To BE COMPLETED BY CONTRACTOR</li> <li>O Original outlier amount (see instructions)</li> <li>O Original outlier amount (see instructions)</li> </ul>		
<ul> <li>21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</li> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>25.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct graduate medical education costs (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 SUB Total used in amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.90 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>30.01 Subtotal (see instructions)</li> <li>31.02 Subtotal (see instructions)</li> <li>32.03 Subtotal (see instructions)</li> <li>33.00 Subtotal (see instructions)</li> <li>34.00 Subtotal (see instructions)</li> <li>35.00 Allowable bad ebers (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 SPECC reconciliation adjustment (see instructions)</li> <li>39.99 Recovery of ACCELERATED DEPRECIATION</li> <li>30.01 Sequestration adjus</li></ul>	0	20. C
<ul> <li>22.00 Interns and residents (see instructions)</li> <li>23.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>26.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>27.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Composite rate ESRD (from Wkst. 1-5, line 11)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 11)</li> <li>ALLOWABLE BAD debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts (see instructions)</li> <li>37.00 Subtotal (inter conciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.90 Prital or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>31.00 Interim payments (see instructions)</li> <li>32.01 Tertial or adjustment (see instructions)</li> <li>33.02 Tertial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 Recovery OF ACCELERATED DEPRECIATION</li> <li>30.00 Subtotal (see instructions)</li> <li>31.01 Tertian payments</li> <li>32.02 Tertial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>33.03 Recovery OF ACCELERATED DEPRECIATION</li> <li>30.04 Subtotal (see instructions)</li> <li>31.05 Protested amounts (see instructions)</li> <li< td=""><td>0</td><td>21.0</td></li<></ul>	0	21.0
<ul> <li>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>25.00 Deductibles and coinsurance (For CAH, see instructions)</li> <li>26.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>20.00 Subtotal (sum of lines 27 through 29)</li> <li>21.00 Primary payer payments</li> <li>22.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>23.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>24.10 owable bad debts (see instructions)</li> <li>25.00 Adjusted reimbursable bad debts (see instructions)</li> <li>26.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>27.00 Subtotal (see instructions)</li> <li>28.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)</li> <li>29.00 Equiption and summent adjustment (see instructions)</li> <li>29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS)</li> <li>20.01 Sequestration adjustment (see instructions)</li> <li>21.02 Fraction adjustment (see instructions)</li> <li>22.03 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>23.00 Interim payments</li> <li>24.00 Interim payments</li> <li>24.00 Fraction adjustment (see instructions)</li> <li>23.00 Balance due provider/program (see instructions)</li> <li>23.00 Balance due provider/program (see instructions)</li> <li>24.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>20 TO BE COMPLETED BY CONTRACTOR</li> <li>20.00 Outlier rec</li></ul>	0	22.0
COMPUTATION OF RELMBURSEMENT SETTLEMENT           25.00         Deductibles and coinsurance (for CAH, see instructions)           26.00         Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)           27.00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)           28.00         Direct graduate medical education payments (from Wkst. E-4, line 50)           29.00         ESR0 direct medical education costs (from Wkst. E-4, line 36)           30.00         Subtotal (sum of lines 27 through 29)           31.00         Primary payer payments           32.00         Composite rate ESRD (from Wkst. I-5, line 11)           ALLOWABLE BAD DEETS (EXCLUDE BAD DEETS FOR PROFESSIONAL SERVICES)           33.00         Composite rate ESRD (from Wkst. I -5, line 11)           44.00         Allowable bad debts (see instructions)           36.00         Allowable bad debts (see instructions)           37.00         Subtotal (see instructions)           38.00         MSP-LCC reconciliation amount from PS&R           39.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)           39.90         Partial or full credits received from manufacturers for replaced devices (see instructions)           39.90         RecovERY OF ACCELERATED DEPRECIATION           400         Subtotal (see inst	0	23.0
<ul> <li>25.00 Deductibles and coinsurance (for CAH, see instructions)</li> <li>26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>41.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>91 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.99 RecoVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Subtotal (see instructions)</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>10 DE COMPLETED BY CONTRACTOR</li> <li>40.00 Outlier reconciliation adjustment (see instructions)</li> <li>41.00 Protested amounts (see instructions)</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>10 DE COMPLETED BY CONTRACTOR</li> <li>40.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	1, 759, 557	24.0
<ul> <li>26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)</li> <li>27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</li> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>20.00 Subtotal (sum of lines 27 through 29)</li> <li>21.00 Primary payer payments</li> <li>23.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>23.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>24.10 Allowable bad debts (see instructions)</li> <li>25.00 Adjusted reimbursable bad debts (see instructions)</li> <li>26.00 Subtotal (see instructions)</li> <li>27.00 Subtotal (see instructions)</li> <li>28.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>25.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>26.00 Subtotal (see instructions)</li> <li>27.00 Subtotal (see instructions)</li> <li>28.00 Subtotal (see instructions)</li> <li>29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>29.00 Prial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>29.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>20.00 Subtotal (see instructions)</li> <li>20.01 Sequestration adjustment (see instructions)</li> <li>20.02 Tentative settlement (for contractors use only)</li> <li>20.03 Balance due provider/program (see instructions)</li> <li>21.04 Derotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2</li> <li>20.00 Original outlier amount (see instructions)</li> <li>20.00 Original outlier amount (see instructions)</li> <li>21.01 Interim payments</li> <li>22.02 Tentative settlement (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15.2</li> <li>21.02 To ECOMPLETED BY CONTR</li></ul>	363, 487	25. C
<ul> <li>instructions)</li> <li>28.00</li> <li>Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00</li> <li>25.00 direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00</li> <li>Subtotal (sum of lines 27 through 29)</li> <li>31.00</li> <li>Primary payer payments</li> <li>32.00</li> <li>Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>Allowable bad debts (see instructions)</li> <li>Adjusted reimbursable bad debts (see instructions)</li> <li>Adjusted reimbursable bad debts (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>Mowable bad debts for dual eligible beneficiaries fo</li></ul>	0	26.0
<ul> <li>28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</li> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>70 DE COMPLETED BY CONTRACTOR</li> <li>70.00 Original outlier amount (see instructions)</li> <li>71.00 Untier reconciliation adjustment amount (see instructions)</li> </ul>	1, 396, 070	27.0
<ul> <li>29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)</li> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31)</li> <li>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. I-5, line 11)</li> <li>40.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>99.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>99.50 Pioneer AC0 demonstration payment adjustment (see instructions)</li> <li>99.99 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>90.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Subtotal (see instructions)</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u></li> <li>70 BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation amount (see instructions)</li> </ul>		20 (
<ul> <li>30.00 Subtotal (sum of lines 27 through 29)</li> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31) <ul> <li>ALLOWABLE BAD DEBTS (EXCLUPE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> </ul> </li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	0	28. C 29. C
<ul> <li>31.00 Primary payer payments</li> <li>32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</li> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u></li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment (see instructions)</li> </ul>		
ALLOWABLEBADDEBTS(EXCLUDEBADDEBTSFORPROFESSIONALSERVICES)33.00Composite rateESRD (fromWkst.I-5, line11)34.00Allowable baddebts (see instructions)35.00Adjusted reimbursable baddebts (see instructions)36.00Allowable baddebts for dual eligible beneficiaries (see instructions)37.00Subtotal (see instructions)38.00MSP-LCC reconciliation amount from PS&R39.00OTHERADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)39.50PioneerACO demonstration payment adjustment (see instructions)39.98Partial or full credits received from manufacturers for replaced devices (see instructions)39.99RECOVERY OF ACCELERATED DEPRECIATION40.00Subtotal (see instructions)40.01Sequestration adjustment (see instructions)41.00Interim payments42.00Tentative settlement (for contractors use only)43.00Balance due provider/program (see instructions)44.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub.44.00Original outlier amount (see instructions)45.01DEBCOMPLETED BY CONTRACTOR40.00Original outlier amount (see instructions)41.00Original outlier amount (see instructions)42.00Original outlier amount (see instructions)43.00Balance due provider/program (see instructions)44.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. <td></td> <td></td>		
<ul> <li>33.00 Composite rate ESRD (from Wkst. 1-5, line 11)</li> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>40.00 Original outlier amount (see instructions)</li> <li>41.00 Original outlier amount (see instructions)</li> </ul>	1, 395, 064	32.0
<ul> <li>34.00 Allowable bad debts (see instructions)</li> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>45.00 Original outlier amount (see instructions)</li> <li>47.00 Original outlier amount (see instructions)</li> <li>47.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>		33. C
<ul> <li>35.00 Adjusted reimbursable bad debts (see instructions)</li> <li>36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)</li> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>45.00 Original outlier amount (see instructions)</li> <li>47.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	40, 871	
<ul> <li>37.00 Subtotal (see instructions)</li> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>		
<ul> <li>38.00 MSP-LCC reconciliation amount from PS&amp;R</li> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	40, 871	36.0
<ul> <li>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> <li>39.00 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>44.00 Original outlier amount (see instructions)</li> <li>47.00 Original outlier amount (see instructions)</li> </ul>		
<ul> <li>39.50 Pioneer ACO demonstration payment adjustment (see instructions)</li> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>45.00 Original outlier amount (see instructions)</li> <li>46.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	0	38. C 39. C
<ul> <li>39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> <li>39.99 RECOVERY OF ACCELERATED DEPRECIATION</li> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u></li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	0	39.0
<ul> <li>40.00 Subtotal (see instructions)</li> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2</li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	0	39.9
<ul> <li>40.01 Sequestration adjustment (see instructions)</li> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2</li> <li>TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>	0	39. 9
<ul> <li>41.00 Interim payments</li> <li>42.00 Tentative settlement (for contractors use only)</li> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>		
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<ul> <li>43.00 Balance due provider/program (see instructions)</li> <li>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> TO BE COMPLETED BY CONTRACTOR</li> <li>90.00 Original outlier amount (see instructions)</li> <li>91.00 Outlier reconciliation adjustment amount (see instructions)</li> </ul>		41.0
§115.2         TO BE COMPLETED BY CONTRACTOR         90.00       Original outlier amount (see instructions)         91.00       Outlier reconciliation adjustment amount (see instructions)		
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)91.00Outlier reconciliation adjustment amount (see instructions)	0	44. C
90.00Original outlier amount (see instructions)91.00Outlier reconciliation adjustment amount (see instructions)		
91.00 Outlier reconciliation adjustment amount (see instructions)	0	90. C
		91.0
92.00 The rate used to calculate the Time Value of Money	0.00	92.0
93.00 Time Value of Money (see instructions) 94.00 Total (sum of lines 91 and 93)		93. C 94. C

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-0167	Period: From 01/01/2016 To 12/31/2016		
		Title		Hospi tal	PPS	
		Inpatient	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		10, 329, 77	72 0	1, 367, 111 0	1. ( 2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	3.0
. 03 . 04				0	0	3. ( 3. (
. 04				0	0	3.
	Provider to Program	II		-1	-	
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
. 54				0	0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as <u>appropriate</u> ) TO BE COMPLETED BY CONTRACTOR		10, 329, 77	72	1, 367, 111	4.
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51				0	0	5.
52				0	Ő	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		1, 55	53 0	26, 086 0	6. 6.
02	Total Medicare program liability (see instructions)		10, 331, 32	-	1, 393, 197	0. 7.
00			10, 001, 02	Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

Heal th	Financial Systems ORTHOPAEDIC HOSPT	. AT PARKVIEW	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0167 Period: Worksheet I From 01/01/2016 Part II To 12/31/2016 Date/Time I 6/28/2017					
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14	2, 685	1.00 2.00	
2.00						
3.00						
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5,49-					
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			406, 079, 922	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			702, 689	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of a line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00	
9.00	Sequestration adjustment amount (see instructions)			0	9.00	
10.00						
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				10.00	
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00		line 31) (see instruction	ıs)	0	32.00	

	Financial Systems ORTHOPAEDIC HOSE E SHEET (If you are nonproprietary and do not maintain the accounting research, complete the Capacal Fund column	Provider C		eriod: rom 01/01/2016	u of Form CMS-: Worksheet G	
una-t <u>i</u> nly)	ype accounting records, complete the General Fund column			o 12/31/2016		
		General Fund	Speci fi c	Endowment Fund	6/28/2017 9:4 Plant Fund	2 an
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	4, 199, 463	C	0	0	1
00	Temporary investments	0	C	0	0	
00	Notes receivable	0	C	0	0	
00	Accounts receivable	20, 202, 524	0	0	0	
00	Other receivable	17, 571		0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	919		0	0	
00	Prepaid expenses	-905, 808		0	0	
00	Other current assets	0		o o	0	
	Due from other funds	0	C	0	0	
. 00	Total current assets (sum of lines 1-10)	23, 514, 669	C	0	0	11
	FIXED ASSETS					
. 00	Land	0	C	0	0	
. 00	Land improvements	0	C	0	0	
	Accumulated depreciation	0		0	0	
	Buildings	9, 446, 043		0	0	
	Accumulated depreciation Leasehold improvements	-2, 336, 883 4, 780, 432		0	0	
	Accumul ated depreciation	-1, 630, 752			0	
	Fixed equipment	157, 301		0	0	
	Accumulated depreciation	-80, 217		o o	0	1 .
	Automobiles and trucks	21, 045	c c	0	0	
	Accumulated depreciation	-7, 453	c	0	0	22
. 00	Major movable equipment	20, 506, 011	C	0	0	23
	Accumulated depreciation	-11, 368, 832	0	0	0	
	Minor equipment depreciable	0	C	0	0	
	Accumulated depreciation	0	C	0	0	1 -
	HIT designated Assets	0		0	0	
	Accumul ated depreciation Minor equipment-nondepreciable			0	0	
	Total fixed assets (sum of lines 12-29)	19, 486, 695		-	0	
	OTHER ASSETS	17, 100, 070				
. 00	Investments	0	C	0	0	31
. 00	Deposits on Leases	0	C	0	0	32
. 00	Due from owners/officers	0	C	0	0	33
	Other assets	58, 289, 927	0	0	0	-
	Total other assets (sum of lines 31-34)	58, 289, 927		-	0	
. 00	Total assets (sum of lines 11, 30, and 35)	101, 291, 291	C	0	0	36
00	CURRENT LI ABI LI TI ES	E 200 242			0	1
	Accounts payable Salaries, wages, and fees payable	5, 298, 242		0	0	
	Payroll taxes payable				0	
	Notes and Loans payable (short term)	7, 580, 000		0	0	
	Deferred income	0	C C	0	0	
	Accelerated payments	0				42
8.00	Due to other funds	0	C	0	0	43
	Other current liabilities	1, 282, 186		-	0	
6.00	Total current liabilities (sum of lines 37 thru 44)	14, 160, 428	C	0	0	45
00	LONG TERM LI ABI LI TI ES					
	Mortgage payable Notes payable	631, 667		0	0	
	Unsecured Loans	031,007			0	
	Other long term liabilities	9, 801, 267		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	10, 432, 934		0	0	
	Total liabilities (sum of lines 45 and 50)	24, 593, 362		0	0	
	CAPI TAL ACCOUNTS					
	General fund balance	76, 697, 929				52
. 00	Specific purpose fund		C			53
	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0	^	56
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	1 26
9.00	Total fund balances (sum of lines 52 thru 58)	76, 697, 929	0	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	101, 291, 291		0	0	
0. 00						

Heal th	Financial Systems 0	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
			0.00	0.00	1.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 201,054,792	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		76, 543, 137				2.00
3.00	Total (sum of line 1 and line 2)		277, 597, 929		0		3.00
4.00 5.00	Additions (credit adjustments) (specify)	0			0	0	4.00 5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00		0			0	0	8.00
9.00		0			0	0	9.00
10. 00 11. 00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		0 277, 597, 929		0		10. 00 11. 00
12.00	TRANSFERS	200, 900, 000	211, 371, 727		0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00 16.00		0			0	0	15. 00 16. 00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		200, 900, 000		0		18.00
19.00	Fund balance at end of period per balance		76, 697, 929		0		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
			FTant	T UNU			
		6.00	7.00	8.00			
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00 2.00
2.00	Total (sum of line 1 and line 2)	0			0		2.00
4.00	Additions (credit adjustments) (specify)	J J	0		0		4.00
5.00			0				5.00
6.00			0				6.00
7.00 8.00			0				7.00 8.00
9.00			0				9.00
10.00	Total additions (sum of line 4–9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00 13.00	TRANSFERS		0				12. 00 13. 00
13.00			0				13.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0		18. 00 19. 00
17.00	sheet (line 11 minus line 18)	0			0		17.00
			'		1		

STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	l: 15-0167	Period: From 01/01/2016 To 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 6/28/2017 9:4	pared:
	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		7, 899, 36	0	7, 899, 360	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY					7.00
8.00 9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 899, 36	50	7, 899, 360	
10.00	Intensive Care Type Inpatient Hospital Services		7,077,30		7,077,300	1 10.00
11.00	INTENSIVE CARE UNIT					1 11. 00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	7, 899, 36	0	7, 899, 360	17.00
18.00	Ancillary services		203, 123, 99	93 120, 754, 525	323, 878, 518	18.00
19.00	Outpatient services			0 0	0	
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00				07 457 455	07 457 455	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )			0 87, 157, 155	87, 157, 155	
26.00				0 ( 100 50(	( 100 E0(	26.00
27.00 28.00	THERAPY REVENUE Total patient revenues (sum of lines 17-27)(transfer column 3	to Wket	211, 023, 35	0 6, 108, 596 53 214, 020, 276	6, 108, 596 425, 043, 629	
26.00	G-3, line 1)	IU WKSL	211, 023, 30	214, 020, 270	425, 045, 029	20.00
	PART II - OPERATING EXPENSES					1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			81, 482, 712		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		81, 482, 712		43.00

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0167	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	arod.
			10 12/31/2010	6/28/2017 9:42	
		÷			
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			425, 043, 629	1.00
2.00	Less contractual allowances and discounts on patients' accoun	its		268, 431, 135	2.00
3.00	Net patient revenues (line 1 minus line 2)			156, 612, 494	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		81, 482, 712	4.00
5.00	Net income from service to patients (line 3 minus line 4)			75, 129, 782	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			200	6.00
7.00	Income from investments			-11, 562	7.00
8.00	Revenues from telephone and other miscellaneous communication	services		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	
13.00	Revenue from Laundry and Linen service			0	
14.00	Revenue from meals sold to employees and guests			0	
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to other t	nan patrents		0	16. 00 17. 00
17.00 18.00	Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts			0	17.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	18.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
20.00	Rental of vending machines			0	20.00
21.00	Rental of hospital space			0	21.00
22.00	Governmental appropriations			0	22.00
23.00	OTHER OPERATING REVENUES			1, 441, 534	
24.00	Total other income (sum of lines 6-24)			1, 430, 172	
26.00	Total (line 5 plus line 25)			76, 559, 954	
20.00	GAIN ON SALE OF ASSET			16, 817	
28.00	Total other expenses (sum of line 27 and subscripts)			16, 817	
	Net income (or loss) for the period (line 26 minus line 28)			76, 543, 137	
27.00			I	, 0, 010, 107	27.00

Heal th Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lie CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0167 Period:				u of Form CMS-2 Worksheet L	
			From 01/01/2016	Parts I-III	
			To 12/31/2016		
		Title XVIII	Hospi tal	6/28/2017 9:42 PPS	2 am
			nospi tai	115	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPI TAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			845, 006	1.0
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2.00	Capital DRG outlier payments			1, 104	2.0
2.01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	15.42	3.0
4.00	Number of interns & residents (see instructions)			0.00	4.0
5.00	Indirect medical education percentage (see instructions)			0.00 0	5.0 6.0
5.00	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		, part A line	0.00	7.C
3.00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8.0
9.00	Sum of lines 7 and 8			0.00	9.0
	Allowable disproportionate share percentage (see instruction	ons)		0.00	10.0
11.00	Disproportionate share adjustment (see instructions)			0	
12.00	Total prospective capital payments (see instructions)			846, 110	12. C
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.0
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.0
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.0
4.00	Capital cost payment factor (see instructions)			0	4.0
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. C
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. C
2.00	Program inpatient capital costs for extraordinary circumsta	nces (see instructions)		0	2.0
8.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.0
. 00	Applicable exception percentage (see instructions)			0.00	4.0
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.0
. 00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6. (
. 00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 x	line 6)	0	7.(
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. (
9.00	Current year capital payments (from Part I, line 12, as app			0	9. (
			Loca Line ()	0	10.0
10. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	10.0

11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 12.00 0 0 13.00 0 14.00 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions) 0 15.00 0 16.00 0 17.00

17.00 Current year exception offset amount (see instructions)