Health Financial Systems ORTHOPAEDIC HOSP	T. AT PARKVI EW	In Lieu	J of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). For payments made since the beginning of the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPI RES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATIO AND SETTLEMENT SUMMARY	N Provider CCN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 7:44 am
PART I - COST REPORT STATUS			
Provider 1. [X] Electronically filed cost report use only 2. [] Manually submitted cost report 3. [0] If this is an amended report enter the numbe 4. [F] Medicare Utilization. Enter "F" for full or	r of times the provider r "!" for low	Date: 5/30/20 esubmitted this co	
Contractor 5. [1] Cost Report Status 6. Date Received: use only (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	10.1 11.0 for this Provider CCN 12.	VPR Date: Contractor's Vendo [0]If line 5, co number of tim	or Code: 4 Iumn 1 is 4: Enter es reopened = 0-9.
PART II - CERTIFICATION			
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR I HEREBY CERTIFY that I have read the above certification electronically filed or manually submitted cost report and Expenses prepared by ORTHOPAEDIC HOSPT. AT PARKVIEW (15-01 01/01/2017 and ending 12/31/2017 and to the best of my kno correct, complete and prepared from the books and records instructions, except as noted. I further certify that I a provision of health care services, and that the services i compliance with such laws and regulations.	FURTHERMORE, IF SERVICES A KICKBACK OR WERE OTHER OF PROVIDER(S) statement and that I have the Balance Sheet and St 67) for the cost reporti wledge and belief, this r of the provider in accord m familiar with the laws	S IDENTIFIED IN TH NISE ILLEGAL, CRIM examined the acco atement of Revenue ng period beginnir eport and statemer ance with applicat and regulations re	IIS REPORT WERE INAL, CIVIL AND mpanying and ng nt are true, ole agarding the
[]I have read and agree with the above certification st signature on this certification statement to be the I			
(Si gne	ed)		
	Officer or Admini	strator of Provid	er(s)
	Title		
	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	4, 632	30, 954	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	4, 632	30, 954	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: 1	5-0167	Period: From 01/01 To 12/31	/2017	Workshe Part I Date/Ti 5/30/20	me Pre	pare
	1.00		00		3.00			4.00			
0	Hospital and Hospital Health Care Co Street: 11119 PARKVIEW PLAZA DRIVE	PO Box:									1.
	City: FORT WAYNE	State: I	N 7	in Code	· 46845_	1705 Coun	tv· ΔLLEN				2.
<u> </u>		Component Na		CCN	CBSA	Provi der	1	Payme	ent Syste	em (P	<u> </u>
		oomponone ne		lumber	Number	Туре	Certi fi ed		, 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					1	1				
0	Hospi tal	ORTHOPAEDIC HOSP	T. AT 1	50167	23060	1	11/08/2007	7 N	P	Р	3.
^	Subprovidor IDE	PARKVI EW									
	Subprovi der – IPF Subprovi der – IRF										4
	Subprovider - (Other)										6
	Swing Beds - SNF										7
	Swing Beds - NF										8
0	Hospital-Based SNF										9.
00	Hospital-Based NF										10.
00	Hospital-Based OLTC										11.
	Hospital-Based HHA										12.
	Separately Certified ASC										13.
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
00	Hospital-Based Health Clinic - FQHC										16.
	Hospital -Based (CMHC) I										17.
00	Renal Dialysis										18
00	Other										19
							From		To:		4
20	Cast Descriptions Descient (see (dd (see a))						1.00		2.0		20
00 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2017	12/31/	2017	20.
00	Type of Control (see instructions) Inpatient PPS Information						4				21.
00	Does this facility qualify and is it	currently receiv	/ing payme	nts for	di sprop	ortionate	· N		N		22.
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en	ter "Y" for yes o	or "N" for	no.							
01	Did this hospital receive interim un						N		N		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)	eporting period c	ccui i i iig i		iter oct						
02	Is this a newly merged hospital that	requires final u	Incompensa	ted car	e paymen	ts to be	N		Ν		22
	determined at cost report settlement	? (see instructio	ons) Enter	in col	umn 1, "	Y" for ye	s				
	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. Did this hospital receive a geograph	i a rochassi fi cati	on from u	rhan ta	rural a	e a rocul	t N		N		22.
	of the OMB standards for delineating								IN		22.
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no			ounted	in accor	dance wit	h				
	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			d/or 25	hal aw?	In column		3	Ν		23
00	1, enter 1 if date of admission, 2 i							3	IN		23.
	method of identifying the days in th	2			0						
	used in the prior cost reporting per										
			In-State			ut-of		Medi ca		ther	
			Medi cai d			State		HMO da	J	i cai d	
			paid days				Medicaid		d	ays	
				unpa dar		d days	el i gi bl e unpai d				
			1.00	2.0		3.00	4.00	5.00	6	. 00	1
)0	If this provider is an IPPS hospital	, enter the		0	0	0	0	5.00	0		24
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col	umn 2,									
	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			0	0	о	0		0		25
	Medicaid paid days in column 1, the			~			U				20.
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid days						1				

	Financial Systems ORTHOPAEDI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		PT. AT PARKVIEW Provider CC	N· 15-0167	In Period:	Li e	u of Form		
1105111	AL AND NOSITIVE HEALTH GAILE COMPLEX TELEVITICATION DAT			N. 13-0107	From 01/01/2 To 12/31/2		Part I	me Pre	pared:
			I		Urban/Rura	al S	Date of	Geogr	
26.00	Enter your standard geographic classification (not wag	ge) sta	atus at the beg	jinning of th	1.00 ne	1	2.0	0	26.00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassific	ge) sta "2" fo	atus at the enc or rural. If ap			1			27.00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		C)		35.00
					Begi nni n	g:	Endi r		
36.00	Enter applicable beginning and ending dates of SCH sta		Subscript line	36 for numbe	1.00 er		2.0	0	36.00
37.00	of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ls MDH status	5	C			37.00
37. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)				N				37.01
38. 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/1 2.0		
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mile with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re	i)? Enter in co equirements in	lumn 1 "Y" accordance	ne Y	39.00			
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	er 1. I	Enter "Y" for y				N		40.00
	· · · · · · · · · · · · · · · · · · ·				-	V 1.00	XVIII 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for (di sproporti opat	e share in a		N	N	N	45.00
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.	ption 1	for extraordina	ary circumsta	inces	N	N	N	46. 00
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS ca <u>Is the facility electing full federal capital payment</u>					N N	N N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in a	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 pr 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 o h of tl ", comp	r "N" for no ir his cost report plete Worksheet	n column 1. I ing period?	f column 1 Enter "Y"	N			57.00
58. 00	If line 56 is yes, did this facility elect cost reimbudefined in CMS Pub. 15-1, chapter 21, §2148? If yes, d	ursemei	nt for physicia	ins' services	as	Ν			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes,					Ν			59.00
				NAHE 413.8 Y/N	5 Workshee Line #		Pass-Th Qualific Criterio	cation	
60.00	Are you claiming purcing and allied health education		costs for	1.00 N	2.00		3.0	0	60.00
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?	see ins	structions)				Di	CME	60.00
		Y/N	IME	Direct GME			Direct		
61.00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0.00	5.0		61.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports								61. 01
51. 02	ending and submitted before March 23, 2010. (see 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								61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61. 03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		Period: From 01/01/2017 To 12/31/2017		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
 51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 51.05 Enter the difference between the baseline primary 		2.00				61. 04 61. 05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. 06
care or general surgery. (see instructions)	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Direct GME FTE	
		1.00	2.00	3.00	Count 4.00	-
51.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	0.00		61.10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
 of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 22.00 Enter the number of FTE residents that your hospital				riad for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruc 52.01 [Enter the number of FTE residents that rotated from a	ctions)					62.00
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	gram. (s	see instructio				
53.00 Has your facility trained residents in nonprovider se	ettings	during this c			N	63.00
"Y" for yes or "N" for no in column 1. If yes, comple	ete line	es 64 through	Unweighted		Ratio (col. 1/	,
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Base Year FTE Residents in No						
period that begins on or after July 1, 2009 and befor 54.00 Enter in column 1, if line 63 is yes, or your facilit	<u>re June</u>	<u>30, 2010.</u>	0.1	0. 00	0. 000000	64 00
in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter ir	n-primar all nor d non-pr	ry care nprovider rimary care	0.1	0.00		04.00
of (column 1 divided by (column 1 + column 2)). (see Program Name		ctions) ogram Code	Unweighted	Unweighted	Ratio (col. 3/	
Program Name	FI	ogram code	FTEs Nonprovi der	FTEsin	(col. 3 + col. 4))	
		0.00	Site		E 00	-
1.00		2.00	3.00	4.00	5.00	

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DAT	A Provider C		eriod: rom 01/01/2017	Worksheet S-2 Part I	
			Тс	0 12/31/2017		pared:
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTËs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	
5.00 Enter in column 1, if line 63	1.00	2.00	0.00			65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Site		_,,,	
	·		1.00	2.00	3.00	
Section 5504 of the ACA Current N beginning on or after July 1, 201		Nonprovider Setting	gsEffective fo	or cost reporti	ng periods	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-primary al. Enter in column 3	/ care resident the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	Si te	4.00	F 00	
7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67.0
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)						
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				1.0		
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	25			1.00	0 2.00 3.00	
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	chiatric Facility (IF	νF), or does it cont	ain an IPF subp		0 2.00 3.00	70. 0
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions)	chiatric Facility (IF the facility have an fore November 15, 200 umn 2: Did this facil & 412.424 (d)(1)(iii)(cate which program yea	approved GME teachi)4? Enter "Y" for y ity train residents (D)? Enter "Y" for y	ng program in t ves or "N" for n s in a new teach ves or "N" for n	rovider? N he most io. (see ing io.	0 2.00 3.00	
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	chiatric Facility (IF the facility have an fore November 15, 200 umn 2: Did this facil & 412.424 (d)(1)(iii)(cate which program yea y PPS	approved GME teachi M? Enter "Y" for y ity train residents (D)? Enter "Y" for y ar began during this	ng program in t ves or "N" for n s in a new teach ves or "N" for n s cost reporting	rovider? N he most io. (see ing io.		70. 0 71. 0 75. 0

Heal th	Financial Systems ORTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 7:4	epared:
					1.00	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for ye Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.	s and "N" for or all of the	no. cost reportin	g period? Enter	N N	80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
	Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section		Ν	87.00
				V 1.00	XI X 2.00	-
	Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (d	ual certificat			N	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applic Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	Ν	N	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the ap	plicable colum	n.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for ye	s or "N" for n	o in the	Ν	N	96.00
	applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in				0. 00 Y	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t				Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.04
	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98.05
	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98.06
105 00	Rural Providers Does this hospital qualify as a CAH?			N		105.00
	If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of paymen			105.00
107.00	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col	n 1. (see inst	ructions) lf	t		107.00
	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N		108.00
		Physi cal	Occupationa		Respi ratory	
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.	1.00 N	2.00	3.00	4.00	109.00
				I	1 00	
110.00	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	lf yes,	1.00 N	110.00

leal th Financial Systems ORTHOPAEDIC HOSPT.AT P HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	vider CCN: 15-0167	Period: From 01/01/ To 12/31/	2017	of For Workshe Part I Date/Ti 5/30/20	et S-2 me Pre	2 epared:
		1.00		2.0	00	1
111.00 If this facility qualifies as a CAH, did it participate in the From Health Integration Project (FCHIP) demonstration for this cost representation program of the FCHIP demonstration for this cost representation prong of the FCHIP demo in which this CAH is participate. Enter all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	orting period? Enter is Y, enter the ting in column 2.	r N				111.00
			1.00	2.00	3.00	1
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" f is yes, enter the method used (A, B, or E only) in column 2. If co 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) bas Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes 117.00 Is this facility legally-required to carry malpractice insurance?	lumn 2 is "E", ente long term care (inc ed on the definition s or "N" for no.	r in column Iudes n in CMS	N N Y		0	115. 00 116. 00 117. 00
no. Ino. Ino. Ino. Ino. Ino. Ino. Ino. I	5		1			118.00
claim-made. Enter 2 if the policy is occurrence.						110.00
	Premiums	Losse	5	Insur	ance	
	1.00	2.00		3. (
18.01 List amounts of malpractice premiums and paid losses:	188, 4	460	0		162	2 118. 0'
18.02 Are malpractice premiums and paid losses reported in a cost center		1.00 N		2.0	00	118. 02
Administrative and General? If yes, submit supporting schedule li and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harml §3121 and applicable amendments? (see instructions) Enter in colum "N" for no. Is this a rural hospital with < 100 beds that qualifie Hold Harmless provision in ACA §3121 and applicable amendments? (see Inter in colum 2, "Y" for yes or "N" for no.	ess provision in AC n 1, "Y" for yes or s for the Outpatien			N		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	devices charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined i Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y the Worksheet A line number where these taxes are included.	n §1903(w)(3) of the ", enter in column :	e N 2				122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes	and "N" for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter th in column 1 and termination date, if applicable, in column 2.	e certification dat	e				126. 0
27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.						127.0
28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the						128. 0 129. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter	the certification					130. 0
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.	r the certification					131. 0
32.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification date					132. 0
33.00 If this is a Medicare certified other transplant center, enter the in column 1 and termination date, if applicable, in column 2.						133.0
34.00 f this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2.	number in column 1					134.00
All Providers 40.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, a are claimed, enter in column 2 the home office chain number. (see	nd home office cost	s Y		15H0	032	140. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	F	<u>PARKVIEW</u> rovider CC	N: 15-0167		: 1/01/2017 2/31/2017		epared:
1.00		2.00				3.00		
If this facility is part of a chain					name an	d address	of the	
home office and enter the home offi 41.00 Name: PARKVIEW HEALTH SYSTEM, INC.		e: WI SCON	SEN PHYSECI		tor's Nu	umber: 0810)1	141. 0
42.00 Street: 10501 CORPORATE DRIVE	PO Box:	SERVI C 5600	-					142.0
43.00 City: FORT WAYNE	State:	IN		Zip Cod	e:	4689	95-5600	142.0
								_
44.00 Area manufalar based abust stand and	- instructed in Wenterle	+ 40					1.00	144.0
44.00 Are provider based physicians' cost	s included in worksh	eet A?					N	144.0
						1.00	2.00	-
45.00 f costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for n ude Medicare utiliza	o in colu	mn 1. lf c	olumn 1 is				145.0
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the processing column 1. (See CMS P				f	N		146. 0
							1.00	-
47.00Was there a change in the statistic	al basis? Enter "Y"	for yes o	r "N" for	no.			N 1.00	147.0
48.00 Was there a change in the order of	allocation? Enter "Y	" for yes	or "N" fo	r no.			N	148. 0
49.00Was there a change to the simplifie	d cost finding metho						N	149. (
			Part A	Part B]	itle V	Title XIX	_
Does this facility contain a provid	or that qualifies fo	r an ever	1.00	2.00	nation o	3.00 f the Lowe	4.00	-
or charges? Enter "Y" for yes or "N								
55.00Hospi tal			N	N		N	N	155. (
56.00 Subprovider - IPF			N	N		N	N	156. (
57.00 Subprovider - IRF			N	N		N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF			N	Ν		N	N	158. 0 159. 0
60.00 HOME HEALTH AGENCY			N	N		N	N	160.0
61. 00 СМНС				Ν		Ν	N	161.0
							1.00	-
Multicampus							1.00	
65.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that ha	s one or	more campu	ses in diff	erent Cl	3SAs?	N	165. 0
	Name		unty		ip Code	CBSA	FTE/Campus	
	0	1	. 00	2.00	3.00	4.00	5.00	01//
66.00 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)							0.0	00 166. (
							1.00	-
Health Information Technology (HIT)	incentive in the Am	erican Re	covery and	Reinvestme	ent Act		1.00	
67.00 Is this provider a meaningful user	under §1886(n)? Ent	er "Y" fo	r yes or "	N" for no.			Y	167. (
58.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	T assets (see instru	ctions)						0168.
58.01 If this provider is a CAH and is no						dshi p		168. (
exception under §413.70(a)(6)(ii)? 59.00 If this provider is a meaningful us transition factor. (see instruction	er (line 167 is "Y")					enter the	9.9	99169. (
	-,				Be	gi nni ng	Endi ng	
			C			1.00	2.00	4
70.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and end	ing date	for the re	porting	10.	/01/2016	09/30/2017	170. (
						1 00	2.00	_
71.00 fline 167 is "Y", does this provi	der have any days fo			led in . 6? Enter		1.00 N	2.00	0171.0

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0167	Peri od: From 01/01/2017 To 12/31/2017 Y/N	Worksheet S-2 Part II Date/Time Pro 5/30/2018 7:4 Date	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			_
	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		1.0
	reporting period: IT yes, enter the date of the change in c	or unit 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			2.0
. 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 ler or its if the board	N			3. 0
			Y/N	Туре	Date	
	Financial Data and Dan-st-		1.00	2.00	3.00	
. 00	Financial Data and Reports 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	Y	A	03/27/2018	4.00
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
			1	Y/N	Legal Oper.	
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s 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.		during the	N N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved	graduate medic	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. 00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.0
					Y/N 1.00	
	Bad Debts				1.00	
	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	12.00 13.00
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><u>v</u> 1</u>		ructions.	N t B	15.0
		Y/N	t A Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 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	Ν		N		16. 00
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	Y	05/01/2018	Y	04/28/2017	17.0
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				5, 20.7	
8. 00	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 cost report? If yes, see instructions.	Ν		Ν		18. 0
			1	1		1

Heal th	Fi nanci al	Systems

ORTHOPAEDI C HOSPT. AT PARKVI EW

In Lieu of Form CMS-2552-10

Health Financial Systems ORTHOPAEDIC HOS	SPT. AT PARKVIEW		In Lie	eu of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2017 To 12/31/2017		Prepared:
	Descr	iption	Y/N	Y/N	
		0	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.00
	-1	1		1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EDT CHILDRENS			1.00	
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
 3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. 		sals made duri	ng the cost	N	23.00
24.00 Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	orting period?		24.00
25.00 Have there been new capitalized leases entered into during instructions.	lfyes, see		25.00		
26.00 Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? If	yes, see		26.00
27.00 Has the provider's capitalization policy changed during th copy.	yes, submit	N	27.00		
Interest Expense28.00Were new Loans, mortgage agreements or Letters of credit e	entered into du	ring the cost	reporting	N	28.00
9.00 period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or		ebt Service Re	serve Fund)	N	29.00
treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions curity with new	debt? If yes,	see	N	30. 00
instructions. B1.00 Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care se	nui ana furni ak	d through con	tractual	N	32.00
arrangements with suppliers of services? If yes, see instr 13.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	uctions.	-		N N	33. 00
Provi der-Based Physi ci ans				I	
34.00 Are services furnished at the provider facility under an a	rrangement with	n provi der-bas	ed_physicians?	N	34.00
If yes, see instructions.			eu physieruns.		01.0
5.00 If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the p	rovi der-based		35.0
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
6.00 Were home office costs claimed on the cost report?7.00 If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Y Y		36. 0 37. 0
If yes, see instructions. 8.00 If line 36 is yes , was the fiscal year end of the home of			Ν		38. 0
the provider? If yes, enter in column 2 the fiscal year en 9.00 If line 36 is yes, did the provider render services to oth			Ν		39. 0
 see instructions. If line 36 is yes, did the provider render services to the instructions. 	e home office?	lf yes, see	Ν		40. 0
	1	00	2	00	_
Cost Report Preparer Contact Information			2.		
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41.00
respectively. 42.00 Enter the employer/company name of the cost report	PARKVI EW HEALT	TH SYSTEM, INC.			42.00
preparer.Bit and email address of the cost	(260) 373-8406	5	ERI C. NI CKESON@	PARKVI EW. COM	43.0
report preparer in columns 1 and 2, respectively.			I		I

Heal th	Financial Systems ORTHOPAEDIC H	OSPT. AT PA	ARKVI EW		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Pro	vider CCN: 15-0167	Perio		Worksheet S-2 Part II	
					01/01/2017 12/31/2017		pared: 0 am
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DI RECTO	R, REIMBURSEMENT				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
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 TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RTHOPAEDIC HOSP AL DATA	Provider CC	CN: 15-0167	Peri od:	u of Form CMS-2 Worksheet S-3	
105111				. 13 0107	From 01/01/2017 To 12/31/2017	Part I Date/Time Prej 5/30/2018 7:40	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	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)	30.00	37	13, 5	0.00	0	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					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		37	13, 5	0.00	0 0	6. 00 7. 00
8.00 9.00 10.00 11.00 12.00 13.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		27	12 5			8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY		37	13, 5	0.00	0 0	14.00 15.00 16.00 17.00 18.00 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	115. 00 30. 00					23.00 24.00 24.10 25.00 26.00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	RUKAL HEALTH CLINIC 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)	89. 00	37 0		0	0	26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0167		eriod: com 01/01/2017 0 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/30/2018 7:4	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 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	1, 821 1, 323 0	13 48 0	5, 26	69			1.00 2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0 0	0 0 0		0			4.00 5.00 6.00
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	1, 821	13	5, 26				7.00 8.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY							9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY	1, 821 0	13 0	5, 26	69 0	0.00	217.81	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
23.00 24.00 24.10 25.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	O	Ο		0	0.00	0.00	24.00 24.10 25.00
26.00 26.25 27.00 28.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0 5	30	0 91	0. 00 0. 00	0. 00 217. 81	26.00 26.25 27.00 28.00
29.00 30.00 31.00 32.00 32.01	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	0		31 0 0 0			29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/30/2018 7:40	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	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 02\\ 27.\ 00\\ 28.\ 00\\ 26.\ 00\\ 0$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SICLITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00 0. 00	0	6	49 4 16 25 0 0 49 4	2, 708	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

	Financial Systems AL WAGE INDEX INFORMATION		THOPAEDI C HOSF	Provider C	F	eriod: rom 01/01/2017 o 12/31/2017		pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. 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							
1.00	Total salaries (see	200.00	20, 330, 355	10, 141, 329	30, 471, 684	1,017,567.00	29. 95	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
	A						0.00	
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A -		0	0	0	0.00	0.00	4.00
4.01	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non		0	0	0	0.00	0.00	5.00
6.00	Physician-Part B Non-physician-Part B for		0	0	0	0.00	0.00	6.00
	hospital-based RHC and FQHC							
7.00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	7.00
	approved program)	200	0	c c				
7.01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7.01
	programs)							
8.00	Home office and/or related		0	6, 565, 513	6, 565, 513	212, 925. 00	30. 83	8.00
9.00	organization personnel SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see		8, 447, 842	1, 779, 241	10, 227, 083	368, 434. 00	27. 76	10.00
	instructions) OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient		0	0	0	0.00	0.00	11.00
12.00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12.00
12.00	management and other management and administrative		0	0		0.00	0.00	12.00
13.00	services Contract Labor: Physician-Part		0	0	0	0.00	0.00	13.00
14 00	A - Administrative		0	0			0.00	14.00
14.00	Home office and/or related orgainzation salaries and		0	0	0	0.00	0.00	14.00
	wage-related costs					040.005.00		
14.01 14.02	Home office salaries Related organization salaries		0	6, 565, 513 0	6, 565, 513 0			14.0 [°] 14.02
15.00	Home office: Physician Part A		0	0	0			15.00
16 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16.00
10.00	Physicians Part A - Teaching		6			0.00	0.00	10.00
17.00	WAGE-RELATED COSTS Wage-related costs (core) (see		5, 288, 816	0	5, 288, 816	1		17.00
17.00	instructions)		0,200,010	0	J, 200, 610			17.00
18.00	Wage-related costs (other)		0	0	0			18.00
19.00	(see instructions) Excluded areas		2, 671, 783	0	2, 671, 783			19.00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
21.00	A Non-physician anesthetist Part		0	0	o			21.00
	В			-	_			
22.00	Physician Part A - Administrative		0	0	0			22.00
22. 01	Physician Part A - Teaching		0	0	0			22.01
23.00 24.00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23.00 24.00
25.00	Interns & residents (in an		0	0	0			25.00
25. 50	approved program) Home office wage-related		2, 757, 035	0	2, 757, 035			25.50
25.50	(core)		2,757,035	0	2,757,035			25.50
25. 51	Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	c			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25.53
20.00	Physicians Part A - Teaching -		0	0				20.03
	wage-related (core)	°C .						
26.00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	2, 686, 764	-2, 686, 764	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,073,552					27.00

Heal th	Financial Systems	OF	RTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/30/2018 7:40	pared:
		Wkst. A Line		Reclassi ficati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
	r	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	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	152, 152	152, 152	2 15, 947. 00	9.54	30.00
31.00	Laundry & Linen Service	8.00	0	0	(0.00	0.00	31.00
32.00	Housekeeping	9.00	221, 907	102, 773	324, 680	19, 554. 00	16.60	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	0	223, 125	223, 125	5 7, 236. 00	30. 84	34.00
35.00	Dietary under contract (see instructions)		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	29, 727	29, 72	7 964.00	30. 84	39.00
40.00	Pharmacy	15.00	0	15, 017	15, 01	487.00	30.84	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	(0.00		
42.00	Social Service	17.00	193, 301	33, 493	226, 794	6, 869. 00	33. 02	42.00
43.00	Other General Service	18.00	0	0	(43.00

Heal th	Financial Systems	O	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2017 To 12/31/2017		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		20, 330, 355	3, 575, 816	23, 906, 17	1 804, 642. 00	29. 71	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		8, 447, 842	1, 779, 241	10, 227, 08	3 368, 434. 00	27.76	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11, 882, 513	1, 796, 575	13, 679, 08	8 436, 208. 00	31.36	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	6, 565, 513	6, 565, 51	3 212, 925. 00	30. 83	4.00
5.00	Subtotal wage-related costs (see inst.)		8, 045, 851	0	8, 045, 85	1 0.00	58. 82	5.00
6.00	Total (sum of lines 3 thru 5)		19, 928, 364	8, 362, 088	28, 290, 45	2 649, 133. 00	43.58	6.00
7.00	Total overhead cost (see instructions)		4, 175, 524	5, 006, 592			32.40	7.00

	t S-3 e Prepared: <u>8 7:40 am</u>
Report	
PART IV - WAGE RELATED COSTS	
Part A - Core List	
1.00 401K Employer Contributions	0 1.00
	2,339 2.00
3.00 Nonqualified Defined Benefit Plan Cost (see instructions)	0 3.00
4.00 Qualified Defined Benefit Plan Cost (see instructions) 64	1, 986 4. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	
5.00 401K/TSA Plan Administration fees	0 5.00
6.00 Legal /Accounting/Management Fees-Pensi on Plan	7,207 6.00
7.00 Employee Managed Care Program Administration Fees 7	4, 813 7.00
HEALTH AND INSURANCE COST	
	8, 129 8. 00
8.01 Health Insurance (Self Funded without a Third Party Administrator)	0 8.01
8.02 Health Insurance (Self Funded with a Third Party Administrator)	0 8.02
8.03 Health Insurance (Purchased)	0 8.03
9.00 Prescription Drug Plan	0 9.00
10.00 Dental, Hearing and Vision Plan	0 10.00
	6, 354 11. 00
12.00 Accident Insurance (If employee is owner or beneficiary)	0 12.00
	5, 677 13. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)	0 14.00
	7,720 15.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0 16.00
Non cumulative portion) TAXES	
	9, 131 17. 00
18.00 Medicare Taxes - Employers Portion Only	0 18.00
19.00 Unemployment Insurance	0 19.00
20.00 State or Federal Unemployment Taxes	0 20.00
20.00 Other	
	3, 207 21. 00
	4,035 22.00
23.00 Tui ti on Rei mbursement	0 23.00
	0, 598 24.00
Part B - Other than Core Related Cost	
25.00 OTHER WAGE RELATED COSTS (SPECIFY)	0 25.00

Heal th	Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0167	Peri od:	Worksheet S-3	
			From 01/01/2017	Part V	
			To 12/31/2017	Date/Time Pre 5/30/2018 7:40	
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Iden	ti fi cati on:			
1.00	Total facility's contract labor and benefi	t cost	0	7, 960, 598	1.00
2.00	Hospi tal		0	7, 960, 598	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems ORTHOPAEDIC HOSPT. AT	PARKVI EW		In Li€	eu of Form CMS-2	2552-10		
		Provider CC	N: 15-0167	Period:	Worksheet S-1			
				From 01/01/2017		norod.		
				To 12/31/2017	Date/Time Pre 5/30/2018 7:4			
					1.00			
	Uncompensated and indigent care cost computation				•			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by lir	ne 202 columr	18)	0. 179510	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				233, 862	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		6 N I	. 10	Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			11 0 ?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om medicalo	1		9, 813, 583	5.00		
6.00 7.00	Medicaid charges				0	6.00 7.00		
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line 7 min	ic cum of lir	voc 2 and E. if	0			
0.00	<pre>c zero then enter zero)</pre>			ies z anu b, TT	0	0.00		
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	<i>y</i>)					
9.00	Net revenue from stand-al one CHIP				0	9.00		
10.00	Stand-al one CHIP charges				0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)		0					
12.00								
	enter zero)					12.00		
	Other state or local government indigent care program (see inst	ructions fo	or each line)					
13.00	0 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 3,851,069 13.00							
14.00	00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 23, 785, 604 14.00							
	10)							
15.00	0 State or local indigent care program cost (line 1 times line 14) 4,269,754 15.00							
16.00	Difference between net revenue and costs for state or local ind	igent care	program (lir	ne 15 minus line	418, 685	16.00		
	13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indig	jent care prograi	ms (see			
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	nding chari	ty care		0	17.00		
17.00	Government grants, appropriations or transfers for support of h				0			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	418, 685			
17.00	8, 12 and 16)	indigent e			410,000	17.00		
			Uni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col. 2)			
			1.00	2.00	3.00			
	Uncompensated Care (see instructions for each line)							
20.00	Charity care charges and uninsured discounts for the entire fac	ility	167, 82	865, 670	1, 033, 494	20.00		
21 00	(see instructions)	nto (coo	20.1		005 704	21 00		
21.00	Cost of patients approved for charity care and uninsured discou instructions)	nts (see	30, 12	865, 670	895, 796	21.00		
22.00	Payments received from patients for amounts previously written	off as		0 3,777	3, 777	22.00		
22.00	chari ty care			5,777	5,777	22.00		
23.00	Cost of charity care (line 21 minus line 22)		30, 12	861, 893	892, 019	23 00		
		1						
					1.00			
24.00	Does the amount on line 20 column 2, include charges for patien	t days beyo	ond a length	of stay limit	N	24.00		
	imposed on patients covered by Medicaid or other indigent care	program?	-	-				
25.00	If line 24 is yes, enter the charges for patient days beyond th	e indigent	care program	n's length of	0	25.00		
	stay limit							
26.00								
27.00	Medicare reimbursable bad debts for the entire hospital complex				30, 485			
27.01	Medicare allowable bad debts for the entire hospital complex (s	ee instruct	tions)		46, 900			
28.00	Non-Medicare bad debt expense (see instructions)				3, 062, 272			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see I	Instructions)		566, 123			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	no 20)			1, 458, 142			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			1, 876, 827	31.00		

alth Financial Systems OI CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OI	RTHOPAEDIC HOSPT F EXPENSES	Provider C	CN: 15-0167	Peri od:	Worksheet A	2552
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/30/2018 7:4	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassificati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	2.00	4.00	<u>col. 4)</u>	+
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
00 00100 CAP REL COSTS-BLDG & FLXT		2, 500, 519	2, 500, 51	9 -1, 214, 035	1, 286, 484	1.
00 00200 CAP REL COSTS-MVBLE EQUIP		0	_,, .	0 1, 214, 035		
00 00300 OTHER CAP REL COSTS		0		0 0	0	
00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 686, 764	5, 631, 971	8, 318, 73	-2, 686, 764	5, 631, 971	4.
00 00500 ADMINI STRATI VE & GENERAL	1, 073, 552	15, 421, 591	16, 495, 14	3 879, 856	17, 374, 999	5.
00 00700 OPERATION OF PLANT	0	798, 146	798, 14	6 0	798, 146	7.
00 00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.
00 00900 HOUSEKEEPI NG	221, 907	282, 610	504, 51	7 38, 449	542, 966	9.
0. 00 01000 DI ETARY	0	223, 125	223, 12	25 0	223, 125	10.
. 00 01100 CAFETERIA	0	0		0 0	0) 11.
2. 00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
8. 00 01300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
. 00 01400 CENTRAL SERVICES & SUPPLY	0	29, 727			29, 727	
5. 00 01500 PHARMACY	0	15, 017	15, 01	7 0	15, 017	
0. 00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
2.00 01700 SOCIAL SERVICE	193, 301	11, 896	205, 19	33, 493		
2.00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
0. 00 02000 NURSING SCHOOL	0	0		0 0	0	
. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	
2. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
B. 00 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	0		0 0	0	23.
0. 00 03000 ADULTS & PEDIATRICS	2, 028, 198	480, 655	2, 508, 85	282, 724	2, 791, 577	30.
ANCI LLARY SERVICE COST CENTERS	2,020,190	460, 000	2, 306, 65	202,724	2, 791, 377	30.
0. 00 05000 OPERATING ROOM	4, 349, 076	27, 584, 016	31, 933, 09	-23, 014, 317	8, 918, 775	50.
8. 00 05300 ANESTHESI OLOGY	222, 577	3, 318			898, 596	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	87, 589				
8. 00 05800 MRI	340, 514	253, 284				
0. 00 06000 LABORATORY	0	445, 710			445, 710	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
6. 00 06500 RESPI RATORY THERAPY	0	76, 472	76, 47	2 0	76, 472	65
0. 00 06600 PHYSI CAL THERAPY	704, 900	26, 970	731, 87	0 121, 980	853, 850	66
2. 00 06900 ELECTROCARDI OLOGY	0	990	99	0 0	990	69
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 3, 174, 640	3, 174, 640	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 20, 032, 742	20, 032, 742	2 72.
8. 00 07300 DRUGS CHARGED TO PATIENTS	61, 724	1, 765, 446	1, 827, 17	10, 695	1, 837, 865	73.
o. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	
0. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
0. 99 07699 LI THOTRI PSY	0	0		0 0	0	0 76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0		0 0	0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					<u> </u>	92.
SPECIAL PURPOSE COST CENTERS				_		4
5.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 059, 528	7, 530, 186				
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 942, 041	63, 169, 238	78, 111, 27	-401, 130	77, 710, 149	1118
NONREI MBURSABLE COST CENTERS			-	-		4
4.00 07951 PHYS THERAPY PERFORMANCE CENTER	5, 388, 314	4,033,452				
0.00 TOTAL (SUM OF LINES 118 through 199)	20, 330, 355	67, 202, 690	87, 533, 04	5 0	87, 533, 045	1200

ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CCN: 15-0167	Period: From 01/01/2017 To 12/31/2017 Date/Time Pr 5/30/2018 7:	repared
Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
00 00100 CAP REL COSTS-BLDG & FIXT	0	1, 286, 484		1.0
00 00200 CAP REL COSTS-BEBG & TTXT	0	1, 214, 035		2.
00 00300 OTHER CAP REL COSTS	0	1, 214, 035		3.
00 00400 EMPLOYEE BENEFITS DEPARTMENT	-320, 625	-		
		5, 311, 346		4.
00 00500 ADMI NI STRATI VE & GENERAL	4, 563, 125	21, 938, 124		5.
00 00700 OPERATION OF PLANT	0	798, 146		7.
00 00800 LAUNDRY & LINEN SERVICE	0	0		8.
00 00900 HOUSEKEEPING	0	542, 966		9.
0.00 01000 DI ETARY	0	223, 125		10.
	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	29, 727		14.
5. 00 01500 PHARMACY	0	15, 017		15.
5. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0		16.
7. 00 01700 SOCIAL SERVICE	0	238, 690		17.
9. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0		19.
D. 00 02000 NURSI NG SCHOOL	0	0		20.
I. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		21.
2.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.
3. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0		23.
INPATIENT ROUTINE SERVICE COST CENTERS	1	1		
0. 00 03000 ADULTS & PEDI ATRI CS	2,869	2, 794, 446		
ANCI LLARY SERVI CE COST CENTERS				
0. 00 05000 OPERATI NG ROOM	-1, 335	8, 917, 440		50.
3. 00 05300 ANESTHESI OLOGY	0	898, 596		53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	86, 346		54.
3. 00 05800 MRI	0	647, 712		58.
0. 00 06000 LABORATORY	0	445, 710		60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.
5. 00 06500 RESPI RATORY THERAPY	0	76, 472		65.
5. 00 06600 PHYSI CAL THERAPY	0	853, 850		66.
9. 00 06900 ELECTROCARDI OLOGY	0	990		69.
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 174, 640		71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	20, 032, 742		72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	-4, 236	1, 833, 629		73.
5. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76.
5. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		76.
5. 99 07699 LI THOTRI PSY	0	0		76.
OUTPATIENT SERVICE COST CENTERS				
D. 00 09000 CLINIC	0	0		90.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
SPECIAL PURPOSE COST CENTERS				
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	189, 926	10, 779, 640		115.
I8.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 429, 724	82, 139, 873		118.
NONREI MBURSABLE COST CENTERS				
24.0007951 PHYS THERAPY PERFORMANCE CENTER	405, 647	10, 228, 543		194.
DO. 00 TOTAL (SUM OF LINES 118 through 199)	4, 835, 371	92, 368, 416		200.

SSI FI CATI ONS			Provider CCN: 15-016	7 Period: From 01/01/201	Worksheet A-6
				To 12/31/2017	7 Date/Time Prepar
	Increases				5/30/2018 7:40 a
Cost Center	Line #	Sal ary	Other		
	3.00	4.00	5.00		
A - BUILDING DEPRECIATON CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 214, 035		
		0	1, 214, 035		
B - MED AND IV SUPPLIES	1	-	.,,		
MEDICAL SUPPLIES CHARGED TO	71.00	0	23, 207, 382		
PATI ENT	0.00				
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	O		
0		o	23, 207, 382		
C - TELEPHONE EXPENSE	F 00		4 140		
ADMI NI STRATI VE & GENERAL	5.00 0.00	0	4, 148 0		
	0.00	<u>0</u>	4, 148		
D - PTO PAID	I		1, 110		
ADMI NI STRATI VE & GENERAL	5.00	15, 495	0		
	9.00	3, 203	0		
SOCIAL SERVICE ADULTS & PEDIATRICS	17.00 30.00	2, 790 29, 274	0		
OPERATING ROOM	50.00	62, 772	0		
ANESTHESI OLOGY	53.00	3, 213	0		
MRI	58.00	4, 915	Ō		
PHYSICAL THERAPY	66.00	10, 174	0		
DRUGS CHARGED TO PATIENTS	73.00	891	0		
PHYS THERAPY PERFORMANCE CENTER	194.00	33, 633	0		10
	+	166, 360	— — <u></u>		
E - PTO EARNED	1				
ADMI NI STRATI VE & GENERAL	5.00	170, 515	0		
HOUSEKEEPING	9.00	35, 246	0		
SOCIAL SERVICE ADULTS & PEDIATRICS	17.00 30.00	30, 703 322, 144	0		
OPERATING ROOM	50.00	690, 776	0		
ANESTHESI OLOGY	53.00	35, 353	O		
MRI	58.00	54, 085	0		
PHYSI CAL THERAPY	66.00	111, 961	0		
DRUGS CHARGED TO PATIENTS PHYS THERAPY PERFORMANCE	73.00	9,804	0		
CENTER	194.00	370, 119	0		10
TOTALS		1, 830, 706	ō		
F - HOME OFFICE					
ADMINI STRATI VE & GENERAL AMBULATORY SURGI CAL CENTER	5.00	5, 190, 024	0		
(D. P.)	115.00	872, 871	0		
PHYS THERAPY PERFORMANCE	194.00	502, 618	О		
<u>CENTER</u>					
0 H - PURCHASED SERVICES		6, 565, 513	0		
ADMI NI STRATI VE & GENERAL	5.00	1,071,337	0		
OPERATION OF PLANT	7.00	152, 152	Ö		
HOUSEKEEPI NG	9.00	64, 324	0		
	10.00	223, 125	0		
CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	29, 727 15, 017	0		
ADULTS & PEDIATRICS	30.00	15, 017 7, 013	0		
OPERATING ROOM	50.00	928, 700	0		
RADI OLOGY-DI AGNOSTI C	54.00	87, 551	0		
LABORATORY	60.00	401, 429	0		10
RESPIRATORY THERAPY	65.00	76, 472	0		1
DRUGS_CHARGED_TO_PATIENTS		<u>518, 969</u> 3, 575, 816	— — <u>0</u>		1:
I - IMPLANTS		5, 575, 610	0		
IMPL. DEV. CHARGED TO	72.00	0	20, 032, 742		
	+				
0 J - ANESTHESIA		0	20, 032, 742		
ANESTHESI OLOGY	53.00	0	634, 135		
0		0	<u> </u>		
L - BONUS DOLLARS RECLASS					
ADMI NI STRATI VE & GENERAL		689, 698	— — <u>0</u>		
TOTALS		689, 698 12, 828, 093	45, 092, 442		500

SSIFICATIONS			T. AT PARKVIEW Provider (CCN: 15-0167	Peri od:	u of Form CMS-2552 Worksheet A-6
					From 01/01/2017 To 12/31/2017	Date/Time Prepare
	Decreases					<u>5/30/2018 7:40 am</u>
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
	7.00	8.00	9.00	10.00		
A - BUILDING DEPRECIATON CAP REL COSTS-BLDG & FIXT	1.00	0	1, 214, 035		9	1.
			1, 214, 035		<u>/</u>	1.
B - MED AND IV SUPPLIES		-1	.,,			
ADULTS & PEDIATRICS	30.00	0	68, 694		0	1.
OPERATING ROOM	50.00	0	23, 132, 204		0	2.
RADI OLOGY-DI AGNOSTI C	54.00	0	1, 243		0	3.
	58.00	0	5, 086		0	4.
PHYSICAL THERAPY	<u> </u>	0	<u>155</u> 23, 207, 382			5.
C - TELEPHONE EXPENSE		9	23, 207, 302			
OPERATING ROOM	50.00	0	1, 526		0	1.
PHYS THERAPY PERFORMANCE	194.00	0	2, 622		0	2.
<u>CENTER</u>	+				_	
O D - PTO PAID		0	4, 148			
EMPLOYEE BENEFITS DEPARTMENT	4.00	166, 360	0	1	0	1.
EWI EOTEE BENEFTTS DEFANTMENT	0.00	0	0		o	2.
	0.00	0	0		0	3.
	0.00	0	0		o	4.
	0.00	0	0		o	5.
	0.00	0	0		0	6.
	0.00	0	0		0	7.
	0.00 0.00	0	0			8.
	0.00	0	0		0	10.
		166, 360	ö			
E – PTO EARNED						
EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 830, 706	0		0	1.
	0.00	0	0		0	2.
	0.00 0.00	0	0			3.
	0.00	0	0			5.
	0.00	0	0		0	6.
	0.00	0	0		o	7.
	0.00	0	0		o	8
	0.00	0	0		o	9
		0	0		Ō	10.
TOTALS F - HOME OFFICE		1, 830, 706	0			
ADMI NI STRATI VE & GENERAL	5.00	0	5, 190, 024		0	1.
AMBULATORY SURGICAL CENTER	115.00	О	872, 871		o	2.
(D.P.)						
PHYS THERAPY PERFORMANCE	194.00	0	502, 618		0	3.
<u>CENTER</u>	+		6, 565, 513		-	
H - PURCHASED SERVICES		<u> </u>	0, 303, 313			
ADMI NI STRATI VE & GENERAL	5.00	0	1,071,337		0	1.
OPERATION OF PLANT	7.00	0	152, 152		o	2.
HOUSEKEEPING	9.00	0	64, 324		0	3.
	10.00	0	223, 125		0	4
CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	29, 727 15, 017			5.
ADULTS & PEDIATRICS	30.00	0	7, 013			7
OPERATI NG ROOM	50.00	o	928, 700		o	8
RADI OLOGY-DI AGNOSTI C	54.00	0	87, 551		o	9
LABORATORY	60.00	0	401, 429		0	10.
RESPIRATORY THERAPY	65.00	0	76, 472		0	11
DRUGS_CHARGED_TO_PATIENTS		0_	518, 969		<u>u</u>	12
U I - IMPLANTS		0	3, 575, 816	1		
MEDICAL SUPPLIES CHARGED TO	71.00	0	20, 032, 742		0	1.
						''
0		0	20, 032, 742]	
J - ANESTHESIA						
OPERATING ROOM	<u>50.</u> 00	0	634, 135		<u>o</u>	1.
U L - BONUS DOLLARS RECLASS		U	634, 135	I		
EMPLOYEE BENEFITS DEPARTMENT	4.00	689, 698	0		0	1.
TOTALS		689, 698	— — — <u> </u>	<u> </u>	1	
00 Grand Total: Decreases		2, 686, 764	55, 233, 771		-	500.

Heal th	Financial Systems 0	RTHOPAEDI C HOSP	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part I	pared:
				Acquisition:			
		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		2.00	0.00	1.00	0.00	
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	o	0		0 0	0	
3.00	Buildings and Fixtures	9, 446, 043	0		0 0	0	3.00
4.00	Building Improvements	4, 780, 432	1, 523, 828		0 1, 523, 828	0	4.00
5.00	Fixed Equipment	8, 786, 262	0		0 0	0	5.00
6.00	Movable Equipment	8, 851, 769	967, 520		0 967, 520	68, 123	6.00
7.00	HIT designated Assets	3, 046, 327	406, 213		0 406, 213	0	7.00
8.00	Subtotal (sum of lines 1-7)	34, 910, 833	2, 897, 561		0 2, 897, 561	68, 123	8.00
9.00	Reconciling Items	573, 289	-120, 831		0 -120, 831	0	9.00
10.00	Total (line 8 minus line 9)	34, 337, 544	3, 018, 392		0 3, 018, 392	68, 123	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	9, 446, 043	765, 352				3.00
4.00	Building Improvements	6, 304, 260	248, 237				4.00
5.00	Fixed Equipment	8, 786, 262	44, 171				5.00
6.00 7.00	Movable Equipment	9, 751, 166	3, 688, 093 0				6.00 7.00
	HIT designated Assets	3, 452, 540	0				8.00
8.00 9.00	Subtotal (sum of lines 1-7) Reconciling Items	37, 740, 271	4, 745, 853 0				9.00
9.00	Total (line 8 minus line 9)	452, 458 37, 287, 813	0				9.00
10.00		31,201,813	4, 745, 853				1 10.00

Heal th	Financial Systems 0	RTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part II Date/Time Pre 5/30/2018 7:4	pared:
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see 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, 500, 519	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, 500, 519	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 500, 519				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2, 500, 519				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0167 Period: From 01/01/2017 Port HI Part III To 12/31/2017 Port HI Part III Date/Time Prepared: 5/30/2018 7: 40 am 5/30/2018 7: 40	Heal th	n Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. 2) Ratio (see instructions) Insurance 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MUBLE EQUIP 9, 751, 165 614, 782 0 24, 536, 565 0.728673 0 2.00 3.00 Total (sum of lines 1-2) 34, 287, 73 4LLOCATION OF OTHER CAPITAL 0 0 2.00 3.00 1.00 2.00 1.00 Cost Center Description Taxes Other closs 5 Total (sum of cols 5 0 <	RECON	CILIATION OF CAPITAL COSTS CENTERS	_	Provider C		rom 01/01/2017	Part III Date/Time Pre	pared:
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Other Total (sum of lines 1-2) 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 24,536,565 0 24,536,565 0.728673 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 24,536,565 0 24,536,565 0.728673 0 2.00 3.00 Total (sum of lines 1-2) 34,287,730 614,782 9,136,383 0.271327 0 2.00 3.00 Total (sum of lines 1-2) 34,287,730 614,782 9,136,383 0.271327 0 2.00 Cost Center Description Taxes Other Total (sum of capital-Relate Costs through 7) 0 0 0 0 0 0 1.00 1.00 Other Costs-MVBLE EQUIP 0 0 0 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 0 0 0 0 0 0 1.00			COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 24, 536, 565 0 24, 505		Cost Center Description		Leases	for Ratio (col. 1 - col. 2)	instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 24,536,565 0 24,536,565 0.728673 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 9,751,165 614,782 9,136,383 0.271327 0 2.00 3.00 Total (sum of lines 1-2) 34,287,730 614,782 9,136,383 0.271327 0 3.00 Cost Center Description Taxes 0 ther Total (sum of lines 1-2) 3.00 1.00 Cost Center Description Taxes 0 ther Total (sum of cols. 5 1.00 Cost Center Description Taxes 0 ther Total (sum of lines 1-2) 0 0 0 1.00 Other Total (sum of lines 1-2) 0 0 0 1.00 1.00 Other Total (sum of lines 1-2) 0 0 0 1.00 2.00 1.00 2.00 Other Total (sum of lines 1-2) 0 0 0 1.00 2.00 3.00 1.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00				2.00	3.00	4.00	5.00	
2.00 CAP REL COSTS-MVBLE EQUIP 9,751,165 614,782 9,136,383 0.271327 0 2.00 3.00 Total (sum of lines 1-2) 34,287,730 614,782 33,672,948 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate Total (sum of cols.5 Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 0 1.00 0 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 1.00 0 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 2.00 1.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 1.00 2.00 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 1.00 2.00 3.00 10.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 Cost Center Description Interest <thi< td=""><td></td><td></td><td></td><td></td><td></td><td>0 700/70</td><td></td><td></td></thi<>						0 700/70		
3.00 Total (sum of lines 1-2) 34,287,730 614,782 33,672,948 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Taxes 0ther Total (sum of lines 1-2) 0 0 3.00 ALLOCATION OF OTHER CAPITAL Cost Center Description Lease Taxes 0ther Cost S through 7) ALLOCATION OF CAPITAL Cost Center Description Lease Other Total (sum of lines 1-2) Other Cost Center Description Lease Other Cost Center Description Interest Insurance (see Taxes (see Other Cost Center Description Interest Insurance (see Instructions) Interest Costs (see							Ű	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.286,484 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.286,484 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 1.286,484 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 1.286,484 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 1.286,484 0 1.00 ALLOCATION OF CAPITAL Interest Insurance (see instructions) Taxes (see instructions) Other instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 11.00 12.00 13.00 14.00 15.00 0 0 0 0 0 0 1.286,484 1.00 1.00 CAP REL COSTS-BLDG & FIXT 0							Ű	
Cost Center Description Taxes Other Capital -Relate d Costs Total (sum of col s. 5 through 7) Depreciation Lease PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.286,484 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 1.286,484 0 1.00 3.00 Total (sum of lines 1-2) 0 0 0 2.00 3.00 1.01 (sum of lines 1-2) 0 0 0 2.00 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) 1.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.286,484 1.00 1.00 12.00 13.00 14.00 15.00 1.286,484	3.00	Total (sum of lines 1-2)						3.00
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Col s. 5 through 7) col s. 5 through 7) col s. 5 through 7) col s. 5 through 7) 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.286,484 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00 2.00 2.00 3.00 2.00 3.00 3.00 3.00 0 0 0 0 2.00 3.00 10.00	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					F CAPITAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Col S. 5 through 7) Col S. 5 through 7) Col S. 5 through 7) Col S. 5 through 7) 1.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.286,484 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00 2.00 2.00 3.00 2.00 3.00 3.00 3.00 0 0 0 0 2.00 3.00 10.00		Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 7.00 8.00 9.00 10.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 1,214,035 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 2.500,519 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 through 14) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 1,214,035 2.00		•		Capi tal -Rel ate				
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,500,519 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Total (2) (sum of cols. 9 11.00 12.00 13.00 14.00 15.00 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 1.00 2.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1.214,035 2.00								
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.00 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">O Nummer of cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">Of colspan="4">O Numer of cost center Description 11.00 12.00 13.00 14.00 15.00 Interest Instructions) 11.00 12.00 13.00 14.00 15.00 Interest Costs-BLDG & FIXT 0 0 0 0 1.00 1.200 1.200 1.200 1.200 1.200 1.200 1.200 1.200 1.200 1.200 1.200 1.20			6.00	7.00	8.00	9.00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1, 214, 035 0 2.00 3.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,500,519 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other of cols. 9 through 14) of cols. 9 through 14) 1.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 2.00 0 0 0 0 1.00 2.00 2.00 CAP REL COSTS-BLDG & FIXT 2.00 0 0 0 0 1.00 2.00			ENTERS					
3.00 Total (sum of lines 1-2) 0 0 0 0 2,500,519 0 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>(</td> <td></td> <td>Ű</td> <td></td>			0	0	(Ű	
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital - Relate d Costs (see instructions) Total (2) (sum of col s. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 2.00			0	0	0		0	
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of col s. 9 through 14) 11.00 12.00 13.00 14.00 15.00 APRT 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0 0 0 1.00 1.00 2.00	3.00	Total (sum of lines 1-2)	0	0	(0	3.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 0 0 1.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1,214,035 2.00				SL	JMMARY OF CAPI	ΓAL		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 11.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 2.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 1.00 12.00 13.00 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 1,214,035 2.00		•		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 1,214,035 2.00						d Costs (see	through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 2.00						instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1,286,484 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 1,214,035 2.00				12.00	13.00	14.00	15.00	
2. 00 CAP REL COSTS-MVBLE EQUI P 0 0 0 1, 214, 035 2. 00					1			
			0	0	0	0		
3.00 Total (sum of lines 1-2) 0 0 0 0 2,500,519 3.00			0	0	0	0 0		
	3.00	Total (sum of lines 1-2)	0	0	(0	2, 500, 519	3.00

n Financial Systems ORTHO

PAEDIC HOSPT. AT PARKVIEW

	Financial Systems MENTS TO EXPENSES	011	TIOL ALDI C TIOSI	PT. AT PARKVIEW Provider CCN: 15-0167	Period:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
				Expense Classification c To/From Which the Amount is		5/30/2018 7:4	
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
	COSTS-MVBLE EQUIP (chapter 2)			CAF REL COSTS-MUBLE EQUIF		-	
3.00	Investment income - other (chapter 2)		0		0.00	0	3.0
1.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
5.00	Refunds and rebates of		0		0.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.0
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.0
	stations excluded) (chapter 21)					-	
3.00	Television and radio service		0		0.00	0	8.0
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.0
0.00	Provi der-based physi ci an	A-8-2	0			0	10. C
1.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.0
2.00	(chapter 23) Related organization	A-8-1	5, 175, 539			0	12.0
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
4.00	Cafeteria-employees and guests		0		0.00	0	14. (
5.00	Rental of quarters to employee and others		0		0.00	0	15.0
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.0
	patients						
7.00	Sale of drugs to other than patients		0		0.00	0	17.0
8.00	Sale of medical records and abstracts		0		0.00	0	18.0
19.00	Nursing and allied health		0		0.00	0	19.0
	education (tuition, fees, books, etc.)						
	Vending machines Income from imposition of		0		0.00 0.00	0	
	interest, finance or penalty		0		0.00	0	
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. (
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.0
	therapy costs in excess of limitation (chapter 14)						
4. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. (
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25.0
5.00	physicians' compensation		0	cost center bereted	114.00		25.0
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
	COSTS-BLDG & FIXT						27.0
	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	
	Non-physician Anesthetist Physicians' assistant		0 0	NONPHYSI CI AN ANESTHETI STS	19.00 0.00	0	28.0 29.0
	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***		J. J	30.0
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 9
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted **'	68.00		31. C
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.0
33.00	OTHER OPERATING REVENUE	В	-10, 154	ADMI NI STRATI VE & GENERAL	5.00	0	33.0

Health Financial Systems	0	RTHOPAEDI C HOSI	PT. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
	_			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 7:4	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 OTHER OPERATING REVENUE	В	-4, 236	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00 SELF INSURANCE OFFSET	A	-320, 625	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	35.00
36.00 NON ALLOWABLE LOBBY EXPENSE	A	-6, 687	ADMI NI STRATI VE & GENERAL	5.00	0	36.00
37.00 TELEMETRY	Α	2, 869	ADULTS & PEDIATRICS	30.00	0	37.00
38.00 OTHER OPERATING REVENUE	В	-1, 335	OPERATING ROOM	50.00	0	38.00
50.00 TOTAL (sum of lines 1 thru 49)		4, 835, 371				50.00
(Transfer to Worksheet A,						
column 6 line 200)						

 col umn 6, line 200.)

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

 (2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-					2552-10	
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0167	Period: From 01/01/2017	Worksheet A-8	3-1
OFFICE				To 12/31/2017	Date/Time Pre 5/30/2018 7:4	
	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	11, 378, 537	6, 798, 571	1.00
2.00	115.00	AMBULATORY SURGICAL CENTER (HOME OFFICE COST REPORT	1, 913, 671	1, 723, 745	2.00
3.00	194.00	PHYS THERAPY PERFORMANCE CEN	HOME OFFICE COST REPORT	1, 101, 933	696, 286	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			14, 394, 141	9, 218, 602	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 amou			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	
-		P INTERPRIATIONSULD TO DELAT	TED ODCANLZATION(S) AND/OD 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 ORT	HOPAEDIC HOSPT. AT PARKVIEW	W	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZAT	IONS AND HOME Provider	CCN: 15-0167 Period: From 01/0 To 12/3	Worksheet A-8-1 1/2017 1/2017 Date/Time Prepared: 5/30/2018 7:40 am

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	4, 579, 966	0		1.00
2.00	189, 926	0		2.00
3.00	405, 647	0		3.00
4.00	0	0		4.00
5.00	5, 175, 539			5.00

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

1143	not been posted to worksheet A,		the amount	arrowable should	be mulcated m	tin s part.	
	Related Organization(s)						
	and/or Home Office						
	Type of Business						
	6.00]					
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S)	AND/OR HOME	OFFICE:			

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

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

reriibur		
6.00	HEALTH SYSTEM	6.00
7.00	ORTHOPAEDI C SERVI CES	7.00
8.00		8.00
9.00 10.00		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.

Health Financial Systems	ORTHOPAEDI C HOSF	PT. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre	narodi
				0 12/31/2017	5/30/2018 7:4	
		CAPI TAL REI	LATED COSTS			
			· · · · · · · · · · · · · · · · · · ·			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	1, 286, 484	1, 286, 484				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	1, 214, 035		1, 214, 035			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5, 311, 346	0	C	-, ,		4.00
5.00 00500 ADMINI STRATI VE & GENERAL	21, 938, 124	297, 220			23, 703, 933	•
7.00 00700 OPERATION OF PLANT	798, 146	0	412, 309		1, 236, 976	
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	, v	0	8.00
9.00 00900 HOUSEKEEPI NG	542, 966	0	0		599, 559	
10. 00 01000 DI ETARY	223, 125	0	40		262, 057	10.00
	0	0		0	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0		0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	29, 727	0		5, 182	34,909	
	15, 017	0		2, 618	17,635	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	238, 690	0		39, 531	0	
	238, 690	0		39, 531	278, 221	17.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL	0	0			0	19.00 20.00
21. 00 02000 NORSTNG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		0	0	20.00
22. 00 02200 I&R SERVICES-SALART & PRINGES APPRV	0	0			0	21.00
23. 00 02200 PARAMED ED PRGM-(SPECIFY)	0	0		-	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	0			0	23.00
30. 00 03000 ADULTS & PEDIATRICS	2, 794, 446	355, 133	52, 143	415, 999	3, 617, 721	30.00
ANCI LLARY SERVICE COST CENTERS			,			
50. 00 05000 OPERATI NG ROOM	8, 917, 440	590, 270	268, 157	1, 051, 284	10, 827, 151	50.00
53. 00 05300 ANESTHESI OLOGY	898, 596	0	0	45, 518	944, 114	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	86, 346	0	0	15, 260	101, 606	54.00
58. 00 05800 MRI	647, 712	24, 795	143, 289	69, 637	885, 433	58.00
60. 00 06000 LABORATORY	445, 710	0	0	69, 971	515, 681	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	76, 472	0	0		89, 801	65.00
66. 00 06600 PHYSI CAL THERAPY	853, 850	19, 066	561	144, 156	1, 017, 633	•
69. 00 06900 ELECTROCARDI OLOGY	990	0	0	0 0	990	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 174, 640	0	0	0 0	3, 174, 640	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 032, 742	0	0	0 0	20, 032, 742	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 833, 629	0	37, 878		1, 974, 588	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0 0	0	•
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	, v	0	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
		0			0	
90.00 09000 CLINIC	0	0	C	0 0		•
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS			I		0	92.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	10, 779, 640	0	157, 779	685, 433	11, 622, 852	115 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	82, 139, 873					•
NONREIMBURSABLE COST CENTERS	02, 139, 873	1, 200, 484	1, 109, 593	4, 214, 157	00, 930, 242	110.00
194.00 07951 PHYS THERAPY PERFORMANCE CENTER	10, 228, 543	0	104, 442	1, 097, 189	11, 430, 174	194 00
200.00 Cross Foot Adjustments	10, 220, 343	0	104, 442	1,077,107		200.00
201.00 Negative Cost Centers		n	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	92, 368, 416	1, 286, 484				
	,, ,	,, , 0 ,	, , 500			

-COST	n Financial Systems (ALLOCATION - GENERAL SERVICE COSTS	ORTHOPAEDIC HOSP	Provider C	CN: 15-0167	Period:	u of Form CMS-2 Worksheet B	2552-10
0031 8	LECONTION - DENEMAL SERVICE COSTS			JN. 13-0107	From 01/01/2017	Part I	,
					To 12/31/2017	Date/Time Prep 5/30/2018 7:40	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	23, 703, 933					5.00
7.00	00700 OPERATION OF PLANT	427, 021	1, 663, 997				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	206, 976	0		0 806, 535		9.00
10.00	01000 DI ETARY	90, 466	0		0 0	352, 523	
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 051	0		0 0	0	
15.00	01500 PHARMACY	6, 088	0		0 0	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17.00	01700 SOCIAL SERVICE	96, 046	0		0 0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	1 0 40 000				050 500	
30.00		1, 248, 888	597, 354		0 289, 536	352, 523	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	2 727 404	992, 868		0 481, 240	0	50.00
53.00	05300 ANESTHESI OLOGY	3, 737, 684 325, 921	992, 808 0		0 481, 240 0 0	0	
53.00		35, 076	0		0 0	0	
58.00	05800 MRI	305, 664	41, 706		0 20, 215	0	
60.00	06000 LABORATORY	178,020	41,708		0 20, 215	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	178,020	0		0 0	0	
62.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPIRATORY THERAPY	31,001	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	351, 301	32, 069		0 15, 544	0	66.00
69.00	06900 ELECTROCARDI OLOGY	342	32, 009 0		0 15, 544	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,095,930	0		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 915, 576	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	681, 655	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	001,000	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	
70. 77	OUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	10.99
90, 00	09000 CLINIC	0	0	1	0 0	0	90.00
90.00		0	0		0	0	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
	D 11500 AMBULATORY SURGICAL CENTER (D. P.)	4,012,371	0	1	0 0	0	115.00
115 00		19, 758, 077	1, 663, 997		0 806, 535	352, 523	
		17,700,077	1,003,997	1	000,000	302, 323	1 10.00
115.00 118.00							
118.00	NONREI MBURSABLE COST CENTERS	3 945 856	0		0 0	0	194 00
118.00 194.00	NONREI MBURSABLE COST CENTERS	3, 945, 856	0		0 0	0	194.00
118.00	NONREIMBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments	3, 945, 856	0		0 0		194. 00 200. 00 201. 00

COST	n Financial Systems 0 ALLOCATION - GENERAL SERVICE COSTS	RTHOPAEDI C HOSP		CN: 15-0167	Peri		u of Form CMS-: Worksheet B	2002-10
0001	ALLOCATION - GENERAL SERVICE COSTS		Trovider d	.cm. 13-0107		01/01/2017 12/31/2017	Part I Date/Time Pre	pared:
	Cost Center Description	CAFETERIA	MAINTENANCE O	NURSI NG		CENTRAL	5/30/2018 7:4 PHARMACY	0 am
	oust center bescription	CALETERIA	PERSONNEL	ADMI NI STRATI	ON S	SERVICES &		
						SUPPLY		
		11.00	12.00	13.00		14.00	15.00	
1 00	GENERAL SERVICE COST CENTERS			1				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP							1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL							5.00
7.00	00700 OPERATION OF PLANT							7.00
8.00	00800 LAUNDRY & LINEN SERVICE							8.00
9.00	00900 HOUSEKEEPING							9.00
10.00								10.00
11.00		0						11.00
12.00		0	(12.00
13.00		0	(0			13.00
14.00		0	(Ō	46, 960		14.00
15.00		0	(Ō	0	23, 723	1
16.00		0	(Ō	ō	0	
17.00		0	(0	0	0	1
19.00		0	(0	0	0	1
20.00	02000 NURSI NG SCHOOL	0	(b	0	0	0	20.00
21.00		0	(b	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	(b	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	(D	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00		0	(ס	0	0	0	30.00
	ANCI LLARY SERVICE COST CENTERS			1	0			50.00
50.00		0			0	0	0	
53.00		0	(0	0	0	
54.00 58.00		0			0	0	0	
60.00		0			0	0	0	1
62.00		0	(0	0	0	
62.30		0	(0	0	0	1
65.00		0			0	0	0	1
66.00		0			0	0	0	66.00
69.00		0			0	0	0	1
71.00		0			0	0	0	1
72.00		0	(0	46, 960	0	1
73.00		0	(0	40, 700	23, 723	
76.97		0	(0	0	20, 720	
76.98		0	(0	0	0	1
76.99		Ő			0	o	0	1
	OUTPATIENT SERVICE COST CENTERS					-1	-	
90.00		0	(D	0	0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
	SPECIAL PURPOSE COST CENTERS	·		·				
115.0	0 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(D	0	0	0	115.00
118.0	0 SUBTOTALS (SUM OF LINES 1 through 117)	0	(0	46, 960	23, 723	118.00
	NONREI MBURSABLE COST CENTERS							
	0 07951 PHYS THERAPY PERFORMANCE CENTER	0	(D	0	0	0	194.00
200.0								200.00
201.0		0		D	0	0		201.00
202.0	0 TOTAL (sum lines 118 through 201)	O	,		0	46, 960	22 222	202.00

		RTHOPAEDIC HOS	PT. AT PARKVI EW			u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/30/2018 7:4	
						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	
	GENERAL SERVICE COST CENTERS	[1	1			1
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5.00 7.00	00700 OPERATION OF PLANT						5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY	0					16.00
	01700 SOCIAL SERVICE	0	374, 267				17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		D		19.00
	02000 NURSI NG SCHOOL	0	0 0		0		20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0 0				23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	374, 267		0 0	0	30.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0		1		0	50.00
	05000 OPERATING ROOM 05300 ANESTHESIOLOGY	0	-			0	
	05400 RADI OLOGY – DI AGNOSTI C				0	0	
	05800 MRI					0	
	06000 LABORATORY	0			0 0	0	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	1
	06500 RESPI RATORY THERAPY	0	0		0 0	0	1
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0 0	(0 C	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 0		0 C	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0 0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0 0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0 0		0 0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0 0		0 0	0	
76. 99		0	0 0		0 0	0	76.99
00.00	OUTPATIENT SERVICE COST CENTERS	0				0	00.00
	09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	90.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0 0		0 0	0	115.00
118.00		0			0 0		118.00
	NONREI MBURSABLE COST CENTERS			1	· · · · ·		1
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	0	0		0 0	0	194.00
					o o	0	200.00
200.00							
200.00 201.00 202.00	Negative Cost Centers	0	0 374, 267			0	201.00 202.00

Heal th	Financial Systems C	RTHOPAEDI C HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0167	Peri od:	Worksheet B	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	narod
					10 12/31/2017	5/30/2018 7:4	
		INTERNS &	·				
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS	PRGM		Residents Cost		
		APPRV			& Post Stepdown		
					Adjustments		
		22.00	23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
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
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
1	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
							15.00
1	01600 MEDICAL RECORDS & LIBRARY						16.00
1	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSI CLAN ANESTHETI STS						19.00
	02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV						20.00
	02200 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0					21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0				22.00
4	INPATIENT ROUTINE SERVICE COST CENTERS		0	/			23.00
	03000 ADULTS & PEDI ATRI CS	0	0	6, 480, 28	39 0	6, 480, 289	30.00
	ANCI LLARY SERVICE COST CENTERS			0, 100, 20	,,,	0, 100, 207	00.00
	05000 OPERATI NG ROOM	0	0	16, 038, 94	3 0	16, 038, 943	50.00
	05300 ANESTHESI OLOGY	0	0			1, 270, 035	
	05400 RADI OLOGY-DI AGNOSTI C	0	0			136, 682	
58.00	05800 MRI	0	0			1, 253, 018	58.00
60.00	06000 LABORATORY	0	0			693, 701	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	120, 80	02 0	120, 802	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1, 416, 54	17 0	1, 416, 547	66.00
1	06900 ELECTROCARDI OLOGY	0	0	1 1 2	32 0	1 1 1 1	
			0			1, 332	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4, 270, 57	0 0	4, 270, 570	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		4, 270, 57 26, 995, 27	70 0 78 0	4, 270, 570 26, 995, 278	71.00 72.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 0 0	4, 270, 57 26, 995, 27 2, 679, 96	70 0 78 0 66 0	4, 270, 570 26, 995, 278 2, 679, 966	71.00 72.00 73.00
72.00 73.00 76.97	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	0 0 0 0	4, 270, 57 26, 995, 27 2, 679, 96	70 0 78 0 66 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0	71.00 72.00 73.00 76.97
72.00 73.00 76.97 76.98	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0 0 0	0 0 0 0 0 0	4, 270, 5 26, 995, 2 2, 679, 96	70 0 78 0 66 0 0 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0	71.00 72.00 73.00 76.97 76.98
72.00 73.00 76.97 76.98 76.99	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY	0	0 0 0 0	4, 270, 5 26, 995, 2 2, 679, 96	70 0 78 0 66 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0	71.00 72.00 73.00 76.97 76.98
72.00 73.00 76.97 76.98 76.99	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS	0 0 0	0 0 0 0 0 0	4, 270, 57 26, 995, 27 2, 679, 96	70 0 78 0 76 0 0 0 0 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0	71.00 72.00 73.00 76.97 76.98 76.99
72.00 73.00 76.97 76.98 76.99 90.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC	0 0 0	0 0 0 0 0 0	4, 270, 57 26, 995, 27 2, 679, 96	0 0 78 0 06 0 0 0 0 0 0 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0 0	71.00 72.00 73.00 76.97 76.98 76.99 90.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0	0 0 0 0 0 0	4, 270, 57 26, 995, 27 2, 679, 96	70 0 78 0 76 0 0 0 0 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0 0	71.00 72.00 73.00 76.97 76.98 76.99
72.00 73.00 76.97 76.98 76.99 90.00 92.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	000000000000000000000000000000000000000		4, 270, 5 26, 995, 2 2, 679, 96		4, 270, 570 26, 995, 278 2, 679, 966 0 0 0	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.)			4, 270, 5 26, 995, 2 2, 679, 96	70 0 78 0 06 0 0 0 0 0 23 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 0 0 15, 635, 223	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117)	000000000000000000000000000000000000000		4, 270, 5 26, 995, 2 2, 679, 96	70 0 78 0 06 0 0 0 0 0 23 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 0 0 15, 635, 223	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 007699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 DBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS			4, 270, 5 26, 995, 2 2, 679, 96 15, 635, 2 76, 992, 38		4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 15, 635, 223 76, 992, 386	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 007699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NORREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER			4, 270, 57 26, 995, 27 2, 679, 96 15, 635, 22 76, 992, 38		4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 0 15, 635, 223 76, 992, 386	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00 194.00 200.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments			4, 270, 57 26, 995, 27 2, 679, 96 15, 635, 22 76, 992, 38		4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 0 15, 635, 223 76, 992, 386 15, 376, 030 0	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 194.00 200.00
72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 115.00 118.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers			4, 270, 57 26, 995, 27 2, 679, 96 15, 635, 22 76, 992, 38 15, 376, 03	ro 78 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 270, 570 26, 995, 278 2, 679, 966 0 0 0 0 15, 635, 223 76, 992, 386 15, 376, 030 0 0	71.00 72.00 73.00 76.97 76.98 76.99 90.00 92.00 115.00 118.00 194.00 200.00 201.00

	Financial Systems C TION OF CAPITAL RELATED COSTS	RTHOPAEDI C HOSF	Provider CO	`N· 15_0167	Period:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TTON OF CAPITAL RELATED COSTS		FIOVICE		From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre 5/30/2018 7:4	
			CAPI TAL REL	ATED COSTS		3/30/2010 7.4	
	Cast Contan Description	Directly			Subtatal		
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-BLDG & FIXT						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	
	00500 ADMI NI STRATI VE & GENERAL	1, 697, 659	297, 220	37, 43	7 2, 032, 316	0	
	00700 OPERATION OF PLANT	0	0	412, 30		0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.00
9.00	00900 HOUSEKEEPI NG	0	0		0 0	0	9.00
10.00	01000 DI ETARY	0	0	4	0 40	0	10.00
	01100 CAFETERI A	0	0		0 0	0	11.00
	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
	01300 NURSING ADMINISTRATION	0	0		0 0	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	1
	01500 PHARMACY	0	0		0 0	0	
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	1
	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	0			0	
	02000 NURSING SCHOOL	0	0			0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	0	355, 133	52, 14	3 407, 276	0	30.00
F0 00	ANCI LLARY SERVICE COST CENTERS		500.070	0/0.45	7 050 407	0	1 50 00
	05000 OPERATING ROOM	0	590, 270 0	268, 15	7 858, 427 0 0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	53.00 54.00
	05800 MRI	0	24, 795	143, 28	9 168, 084	0	
	06000 LABORATORY	0	24, 775	143, 20	0 100,004	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	19, 066	56	1 19, 627	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
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	37, 87	8 37, 878	0	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	1 . 0
	07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY	0	0		0 0	0	
	OTPATIENT SERVICE COST CENTERS	0	0		0 0	0	1 /0.99
	09000 CLINIC	0	0		0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ŭ	0		0	Ŭ	92.00
	SPECIAL PURPOSE COST CENTERS						1
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	157, 77	9 157, 779	0	115.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 697, 659	1, 286, 484	1, 109, 59	3 4, 093, 736	0	118.00
	NONREIMBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	0	0	104, 44	2 104, 442		194.00
200.00					0		200.00
		1 1	0		0	0	201.00
201.00 202.00		1, 697, 659	1, 286, 484	1, 214, 03	5 4, 198, 178		202.00

		ORTHOPAEDIC HOSP				u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/30/2018 7:4	
	Cost Center Description	& GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVIC		DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 032, 316					5.00
7.00	00700 OPERATION OF PLANT	36, 612	448, 921				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0		8.00
9.00	00900 HOUSEKEEPI NG	17, 746	0		0 17, 746		9.00
10.00	01000 DI ETARY	7, 756	0		0 0	7, 796	10.00
11.00	01100 CAFETERI A	0	0		0 0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1,033	0		0 0	0	14.00
15.00	01500 PHARMACY	522	0		0 0	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	
17.00	01700 SOCIAL SERVICE	8, 235	0		0 0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0, 233	0		0 0	0	
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	1
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
22.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	U	0		0 0	0	23.00
30, 00	03000 ADULTS & PEDIATRICS	107,077	161, 157	[0 6, 371	7, 796	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	107,077	101, 137		0 0, 371	7,790	30.00
50.00	05000 OPERATI NG ROOM	320, 462	267, 860		0 10, 588	0	50.00
53.00	05300 ANESTHESI OLOGY	27,944	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3,007	0		0 0	0	54.00
58.00	05800 MRI	26, 207	11, 252		0 445	0	58.00
60.00	06000 LABORATORY	15, 263	0		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	2, 658	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	30, 120	8, 652		0 342	0	1
69.00	06900 ELECTROCARDI OLOGY	29	0,002		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	93, 963	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	592, 915	0		0 0	0	
72.00	07300 DRUGS CHARGED TO PATIENTS	58, 444	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	58, 444	0		0 0	0	
76.97		0	0		0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
/0.99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	/0.99
90.00	09000 CLINIC	0	0		0 0	0	90.00
		0	0		0 0	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS						92.00
115 00		244 012	0	[0 0	Ō	115 00
115.00	11500 AMBULATORY SURGI CAL CENTER (D. P.)	344,013					115.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 694, 006	448, 921		0 17,746	7, 796	118.00
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	338, 310	0		0 0	0	194.00
200.00			0			Ū	200.00
201.00	,	0	0		0 0	n	201.00
201.00	0	2, 032, 316	448, 921		0 17, 746		202.00
202.00		2,002,010	721	I	S 17,740	7,770	1202.00

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre	naradi
					10 12/31/2017	5/30/2018 7:4	
	Cost Center Description	CAFETERIA M.	AINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI (CENTRAL ON SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	0					11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSING ADMINISTRATION	0	0		0		13.00
14.00		0	0		0 1, 033		14.00
15.00	01500 PHARMACY	0	0		0 0	522	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	C		0 0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	C		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	C		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C		0 0	0	22.00
23.00		0	0		0 0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
F0 00	ANCI LLARY SERVI CE COST CENTERS					0	50.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
58.00		0	0		0 0	0	
60.00	06000 LABORATORY	0	U		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	U		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	U		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	U		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1,033	0	
73.00 76.97	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	522	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	-	
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	1	0 0	0	
70.99	OUTPATIENT SERVICE COST CENTERS	0	0	1	<u> </u>	0	70.99
90.00		0	C		0 0	0	90.00
92.00		U	0	'	0	0	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
115 00	D11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0 0	0	115.00
118.00		0	C		0 1,033		118.00
	NONREI MBURSABLE COST CENTERS	<u> </u>	0		-, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	522	1
110.00		0	C		0 0	0	194.00
	JO7951 PHYS THERAPY PERFORMANCE CENTER	0					
194.00	007951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments	0	0		J J		
	Cross Foot Adjustments	0	C		0 0		200. 00 201. 00

ALLOCA	Financial Systems 0 TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part II	
			_		To 12/31/2017	Date/Time Pre 5/30/2018 7:40	
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	ANESTHETI STS	NURSING SCHOOL		
		16.00	17.00	19.00	20.00	21.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 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
	01000 DI ETARY						10.00
	01100 CAFETERIA						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	C					16.00
17.00	01700 SOCIAL SERVICE	C	8, 235				17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	C	0 0		0		19.00
20.00	02000 NURSING SCHOOL	C	0 0		0		20.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRV	C	0 0			0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	0 0				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	C	0 0				23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		- 1		
30.00	03000 ADULTS & PEDIATRICS	C	8, 235				30.00
	ANCI LLARY SERVICE COST CENTERS	-	-	1			
	05000 OPERATING ROOM	C	-				50.00
	05300 ANESTHESI OLOGY	C					53.00
	05400 RADI OLOGY-DI AGNOSTI C	0					54.00
							58.00
							60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS						62.00 62.30
	06500 RESPIRATORY THERAPY						65.00
	06600 PHYSI CAL THERAPY						66.00
	06900 ELECTROCARDI OLOGY						69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS						72.00
	07300 DRUGS CHARGED TO PATIENTS		ol o				73.00
	07697 CARDI AC REHABI LI TATI ON		ol o				76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	C	0				76.98
76.99	07699 LI THOTRI PSY	C	0				76.99
	OUTPATIENT SERVICE COST CENTERS]
90.00	09000 CLI NI C	C	0 0				90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	C					115. OC
118.00		C	8, 235		0 0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	C	0 0				194.00
200.00					0 0		200. 00
201.00		C	-		0 0		201.00 202.00
202.00	TOTAL (sum lines 118 through 201)	C	8, 235		0 0		

	Financial Systems C TION OF CAPITAL RELATED COSTS	RTHOPAEDI C HOSP	Provider C	CN: 15-0167	Period:	eu of Form CMS-: Worksheet B	2552-10
ALLUCA	TTON OF CAPITAL RELATED COSTS		FIOVIDEI C		From 01/01/2017	Part II	
					To 12/31/2017	Date/Time Pre 5/30/2018 7:4	epared: 10 am
		INTERNS &					T
	Cast Castas Description	RESI DENTS		Culture	Latera 0	Tatal	
	Cost Center Description	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	Total	
		APPRV	T KOM		& Post		
					Stepdown		
		22.00	22.00	24.00	Adjustments	24.00	
	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 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 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
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS						17.00 19.00
20.00	02000 NURSI NG SCHOOL						20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		0				23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS			(07.04		(07.010	
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS			697, 91	2 0	697, 912	30.00
50.00	05000 OPERATI NG ROOM			1, 457, 33	7 0	1, 457, 337	50. 00
53.00	05300 ANESTHESI OLOGY			27,94			
54.00	05400 RADI OLOGY-DI AGNOSTI C			3, 00			
58.00	05800 MRI			205, 98	8 0	205, 988	58.00
60.00	06000 LABORATORY			15, 26			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0		
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS				0 0 8 0		
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			2, 65 58, 74	-		1
69.00	06900 ELECTROCARDI OLOGY				9 0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			93, 96			
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			593, 94	8 0	593, 948	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS			96, 84			73.00
	07697 CARDI AC REHABI LI TATI ON			1	0 0		
	07698 HYPERBARI C OXYGEN THERAPY				0 0		
/6.99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS				0 0	0	76.99
90.00	09000 CLINIC				0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·					
	11500 AMBULATORY SURGICAL CENTER (D. P.)			501, 79			
	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	3, 755, 42	6 0	3, 755, 426	118.00
115. 00 118. 00							
118.00	NONREI MBURSABLE COST CENTERS			110 75	2 0	112 752	101 00
118.00 194.00	NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER			442, 75			
118.00	NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adj ustments	0	0		2 0 0 0 0 0	0	194.00 200.00 201.00

		RTHOPAEDI C HOSI				u of Form CMS-2	
CUST A	LLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2017 o 12/31/2017	Worksheet B-1 Date/Time Pre	
		CAPI TAL REI	LATED COSTS			5/30/2018 7:4	0 am
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	80, 837	2, 798, 231				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 790, 231	30, 471, 684			4.00
5.00	00500 ADMINI STRATI VE & GENERAL	18, 676	86, 289	8, 210, 621	-23, 703, 933	68, 664, 483	5.00
7.00	00700 OPERATION OF PLANT	0	950, 329	152, 152	0	1, 236, 976	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
	00900 HOUSEKEEPI NG	0	0	324, 680	0	599, 559	
	01000 DI ETARY 01100 CAFETERI A	0	93	223, 125 0	0	262, 057 0	10.00
	01200 MAINTENANCE OF PERSONNEL		0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	29, 727	0	34, 909	14.00
	01500 PHARMACY	0	0	15, 017	0	17, 635	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
	01700 SOCI AL SERVI CE	0	0	226, 794	0	278, 221	
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19.00 20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV		0	0	0	0	20.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	22, 315	120, 185	2, 386, 629	0	3, 617, 721	30.00
	05000 OPERATI NG ROOM	37, 090	618, 076	6, 031, 324	0	10, 827, 151	50.00
	05300 ANESTHESI OLOGY	0	0	261, 143	0	944, 114	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	87, 551	0	101, 606	54.00
	05800 MRI	1, 558	330, 268	399, 514	0	885, 433	
	06000 LABORATORY	0	0	401, 429	0	515, 681	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.00 62.30
	06500 RESPIRATORY THERAPY	0	0	76, 472	0	89, 801	
	06600 PHYSI CAL THERAPY	1, 198	1, 292	827, 035	0	1, 017, 633	
	06900 ELECTROCARDI OLOGY	0	0	0	0	990	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3, 174, 640	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20, 032, 742	
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	87, 306	591, 388 0	0	1, 974, 588 0	
	07698 HYPERBARI C OXYGEN THERAPY		0	0	0	0	
	07699 LI THOTRI PSY	0	0	0	0		
	OUTPATIENT SERVICE COST CENTERS	T					
	09000 CLINIC	0	0	0	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	363, 665	3, 932, 399	0	11, 622, 852	115 00
118.00		80, 837					
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	0	240, 728	6, 294, 684	0		
200.00	5						200.00
201.00	5	1 204 404	1 014 005	E 011 044			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 286, 484	1, 214, 035	5, 311, 346		23, 703, 933	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 914544	0. 433858	0. 174304		0. 345214	203.00
204.00				0		2, 032, 316	
	Part II)						
205.00				0. 000000		0. 029598	205.00
206.00	II) NAHE adjustment amount to be allocated						206.00
200.00	(per Wkst. B-2)						200.00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)					l	I

IA	LLUCAI	ION - STATISTICAL BASIS		Provider C	1	Period: From 01/01/2017 Fo 12/31/2017	Worksheet B-1 Date/Time Pre	
				_		10 12/31/2017	5/30/2018 7:4	
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		CAFETERIA (MEALS SERVED)	
	_		7.00	8.00	9.00	10.00	11.00	
		AL SERVICE COST CENTERS	1	1	1	1		
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00200 00400 00500 00700 00800 01000 01200 01200 01300 01400 01500 01600 01700 01900 02000 02100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMI NI STRATI VE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINI STRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING SCHOOL I &R SERVICES-SALARY & FRINGES APPRV	62, 161 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			21, 148 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12. 13. 14. 15. 16. 17. 19. 20. 21.
		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	
00		PARAMED ED PRGM-(SPECIFY) ENT ROUTINE SERVICE COST CENTERS	0) C) (0 0	0	23.
00		ADULTS & PEDIATRICS	22, 315	i c	22, 31	5 21, 148	0	30
		LARY SERVICE COST CENTERS	22, 515	<u>, </u>	22, 31	21,140	0	
00	05000	OPERATING ROOM	37, 090	0	37, 090	0 0	0	50.
		ANESTHESI OLOGY	0	0			0	
		RADI OLOGY-DI AGNOSTI C	0	0		-	0	
	05800		1, 558	0	1, 558		0	
		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	
		BLOOD CLOTTING FOR HEMOPHILIACS				-	0	
		RESPI RATORY THERAPY	0			-	0	
		PHYSI CAL THERAPY	1, 198		1, 198		0	
		ELECTROCARDI OLOGY	0	0) (0	
00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71
		IMPL. DEV. CHARGED TO PATIENTS	0	0) (0 0	0	1
		DRUGS CHARGED TO PATIENTS	0	0			0	
			0				0	1
		HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	0				0	
		TI ENT SERVICE COST CENTERS			<u>/</u>	<u> </u>	0	1 /0
		CLINIC	0) (0 0	0	90
		OBSERVATION BEDS (NON-DISTINCT PART						92
		AL PURPOSE COST CENTERS						
. 00		AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	0 62, 161			0 0 1 21, 148		115 118
		PHYS THERAPY PERFORMANCE CENTER	0			0 0	0	194
. 00		Cross Foot Adjustments					0	200
. 00		Negative Cost Centers						201
. 00		Cost to be allocated (per Wkst. B,	1, 663, 997	0	806, 53	5 352, 523	0	202
		Part I)						
. 00 . 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	26. 769148 448, 921		12. 974930 17, 740			203 204
. 00		Unit cost multiplier (Wkst. B, Part	7. 221908	0. 000000	0. 285484	0. 368640	0. 000000	205
. 00		II) NAHE adjustment amount to be allocated						206
~		(per Wkst. B-2)						007
. 00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		1				207

	inancial Systems _OCATION - STATISTICAL BASIS	UKTHUFALDIC HUS	PT. AT PARKVIEW Provider CC	N· 15-0167	Peri od:	u of Form CMS-25 Worksheet B-1
	LOATION STATISTICAL DASIS				From 01/01/2017 To 12/31/2017	Date/Time Prep
					10 12/31/2017	5/30/2018 7:40
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL
		PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS &
		HOUSED)	(DIRECT NRSING	(COSTED	REQ013.)	(TIME SPENT)
			HRS)	REQUIS.)		(
		12.00	13.00	14.00	15.00	16.00
	ENERAL SERVICE COST CENTERS		1			
	0100 CAP REL COSTS-BLDG & FIXT					
1	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT					
	0500 ADMI NI STRATI VE & GENERAL					
	0700 OPERATION OF PLANT					
	0800 LAUNDRY & LINEN SERVICE					
00 00	0900 HOUSEKEEPI NG					
. 00 0	1000 DI ETARY					
	1100 CAFETERI A					
	1200 MAINTENANCE OF PERSONNEL	0				
	1300 NURSING ADMINISTRATION	0	0		2	
	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY		0	55, 658, 16	0 10,000	
	1600 MEDICAL RECORDS & LIBRARY				0 10,000	О
	1700 SOCIAL SERVICE	0	0		0 0	0
	1900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0
	2000 NURSI NG SCHOOL	0	0		0 0	0
	2100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0
. 00 0	2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0
	2300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS	0	0		0 0	0
	NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM	0	0		0 0	0
	5300 ANESTHESI OLOGY				0 0	0
	5400 RADI OLOGY-DI AGNOSTI C		0			0
	5800 MRI	0	0		0 0	Ő
	6000 LABORATORY	0	0		0 0	0
0 00	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0
. 30 0	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0
	6500 RESPI RATORY THERAPY	0	0		0 0	0
	6600 PHYSI CAL THERAPY	0	0		0 0	0
	6900 ELECTROCARDI OLOGY	0	0		0 0	0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	FF (FO 1/	0 0	0
	7200 I MPL. DEV. CHARGED TO PATI ENTS 7300 DRUGS CHARGED TO PATI ENTS	0	0	55, 658, 16	0 10,000	0
	7697 CARDI AC REHABI LI TATI ON		0		0 10,000	0
	7698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0
	7699 LI THOTRI PSY	0	Ő		0 0	0
	UTPATIENT SERVICE COST CENTERS					
. 00 0	9000 CLI NI C	0	0		0 0	0
	9200 OBSERVATION BEDS (NON-DISTINCT PART					
	PECIAL PURPOSE COST CENTERS		1 1		_ _	
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0		FF (50);	0 0	01
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	55, 658, 16	2 10,000	01
	ONREIMBURSABLE COST CENTERS 7951 PHYS THERAPY PERFORMANCE CENTER	0				01
1. 00 0 D. 00	Cross Foot Adjustments					2
1.00	Negative Cost Centers					2
2.00	Cost to be allocated (per Wkst. B,	0	о	46, 96	0 23, 723	0 2
	Part I)					
3. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.00084	4 2. 372300	0. 000000 2
4.00	Cost to be allocated (per Wkst. B,	0	0	1, 03	3 522	0 2
	Part II)					
5.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00001	9 0. 052200	0. 000000 2
6 00) NAME adjustment amount to be all ecator	4				
6.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	'				2
7 00	NAHE unit cost multiplier (Wkst. D,					2
7.00						

	Financial Systems 0 LLOCATION - STATISTICAL BASIS	RTHOPAEDIC HOSI	PT.AT PARKVIEW		In Lie	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2017 o 12/31/2017		pared:
					INTERNS &		
	Cost Center Description	SOCI AL SERVI CE		NURSING SCHOOL	SERVI CES-SALAR		
		(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRI NGES APPRV	PRGM COSTS APPRV	
			TIME)	TIME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	
	GENERAL SERVI CE COST CENTERS	17.00	19.00	20.00	21.00	22.00	
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 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	10,000					16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0				19.00
	02000 NURSING SCHOOL	0		C			20.00
	02100 I & R SERVI CES-SALARY & FRINGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0			0	0	21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)	0				0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	10.000					
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	10,000	0) C	0	0	30.00
	05000 OPERATI NG ROOM	0	0	0	0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	53.00 54.00
	05800 MRI	0	0		-	0	
	06000 LABORATORY	0	0	c c	-	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		-	0	62.00 62.30
	06500 RESPIRATORY THERAPY	0	0			0	
	06600 PHYSI CAL THERAPY	0	0	C	-	0	66.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		-	0	69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0) C	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0		-	0	
	07699 LI THOTRI PSY	0	0		0	0	
00.00	OUTPATIENT SERVICE COST CENTERS	0	0		ol	0	90.00
	09000 CETNIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	90.00
	SPECIAL PURPOSE COST CENTERS			1			
115.00 118.00	11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117)	0 10, 000	0				115. 00 118. 00
116.00	NONREIMBURSABLE COST CENTERS	10,000	0	<u>η</u> τ	v <u> </u>	0	116.00
	07951 PHYS THERAPY PERFORMANCE CENTER	0	0	C	0	0	194.00
200.00 201.00	5						200.00
201.00	5	374, 267	0) c	0	0	201.00
	Part I)	07 404700					
203.00 204.00		37. 426700 8, 235	0. 000000	0.00000	0.000000	0.000000	203.00 204.00
204.00	Part II)	0,233					
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 823500	0. 000000	0. 000000	0. 000000	0. 000000	205.00
206.00	NAHE adjustment amount to be allocated			C			206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,			0.000000			207.00
207.00	Parts III and IV)						207.00

ST ALLOCATI	al Systems 0 DN - STATISTICAL BASIS	RTHOPAEDI C HOSPT	Provi der CCN: 15-0167	Peri od:	u of Form CMS-2552- Worksheet B-1
				From 01/01/2017	
				To 12/31/2017	Date/Time Prepared 5/30/2018 7:40 am
С	ost Center Description	PARAMED ED		J.,	
		PRGM			
		(ASSI GNED TI ME)			
		23.00			
GENERAL	SERVICE COST CENTERS				
1 1	AP REL COSTS-BLDG & FIXT				1. (
	AP REL COSTS-MVBLE EQUIP				2. (
	MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL				4. (
	PERATION OF PLANT				7.0
	AUNDRY & LINEN SERVICE				8.0
	OUSEKEEPING				9. (
. 00 01000 D	I ETARY				10.0
	AFETERIA				11. (
	AINTENANCE OF PERSONNEL				12. (
	URSING ADMINISTRATION				13. (
	ENTRAL SERVICES & SUPPLY				14. (
.00 01500 P .00 01600 M	HARMACY EDICAL RECORDS & LIBRARY				15. (
	OCIAL SERVICE				17.0
	ONPHYSICIAN ANESTHETISTS				17.0
	URSING SCHOOL				20.0
. 00 02100 1	&R SERVICES-SALARY & FRINGES APPRV				21. (
. 00 02200 1	&R SERVICES-OTHER PRGM COSTS APPRV				22. (
	ARAMED ED PRGM-(SPECIFY)	0			23.0
	NT ROUTINE SERVICE COST CENTERS				
	DULTS & PEDIATRICS	0			30. (
	RY SERVICE COST CENTERS PERATING ROOM	0			50.0
	NESTHESI OLOGY	0			53.0
	ADI OLOGY-DI AGNOSTI C	0			54.0
. 00 05800 M	RI	0			58.0
	ABORATORY	0			60.0
	HOLE BLOOD & PACKED RED BLOOD CELL	0			62.0
	LOOD CLOTTING FOR HEMOPHILIACS	0			62.3
	ESPI RATORY THERAPY HYSI CAL THERAPY	0			65. (66. (
1 1	LECTROCARDI OLOGY	0			69.0
1 1	EDICAL SUPPLIES CHARGED TO PATIENT	0			71. 0
	MPL. DEV. CHARGED TO PATIENTS	0			72.0
	RUGS CHARGED TO PATIENTS	0			73.0
. 97 07697 C	ARDI AC REHABI LI TATI ON	0			76.9
	YPERBARI C OXYGEN THERAPY	0			76.9
		0			76.9
. 00 09000 C	ENT SERVICE COST CENTERS	0			90.0
	BSERVATION BEDS (NON-DISTINCT PART	0			90.0
	PURPOSE COST CENTERS	I			
5.0011500 A	MBULATORY SURGICAL CENTER (D. P.)	0			115. (
	UBTOTALS (SUM OF LINES 1 through 117)	0			118. (
	BURSABLE COST CENTERS	1			
	HYS THERAPY PERFORMANCE CENTER	0			194. (
	ross Foot Adjustments egative Cost Centers				200. (201. (
	ost to be allocated (per Wkst. B,	0			201.0
	art I)				202.0
	nit cost multiplier (Wkst. B, Part I)	0. 000000			203. (
	ost to be allocated (per Wkst. B,	0			204.0
	art II)				
	nit cost multiplier (Wkst. B, Part	0. 000000			205. 0
) AVE adjustment amount to be allocated				204 (
	AHE adjustment amount to be allocated per Wkst. B-2)	0			206. (
	AHE unit cost multiplier (Wkst. D,	0. 000000			207. 0
	arts III and IV)				

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0167 Period: From 01/01/2017 Worksheet C From 01/01/2017 Very State Title XVIII Hospital PPS Cost Center Description Total Cost (from Wkst. B, Part I, col.) Total Cost (from Wkst. B, Part I, col.) Total Costs RCE Total Costs RCE 03000 ADULTS & PEDIATIE CS 6, 480, 289 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 16, 038, 943 0 16, 038, 943 50. 00 12, 270, 035 0 1, 270, 035 0 1, 270, 035 0 1, 270, 035 0 1, 270, 035 0 1, 253, 018 0 16, 038, 943 50. 00 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 16, 038, 943 0 16, 038, 943 50. 00 1, 270, 035 0 1, 270, 035 0 1, 270, 035 0 1, 270, 035 0 1, 253, 018 0 1, 253, 018 0 <th>Health Financial Systems</th> <th>ORTHOPAEDI C HOSE</th> <th>PT. AT PARKVI EW</th> <th></th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Health Financial Systems	ORTHOPAEDI C HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Therapy Limit Adj. Total Costs (Total Costs Total Costs Total Costs Total Costs Total Costs RCE Total Costs RCE Total Costs Image: Cost Centers 30.00 INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 OS000 ADULTS & PEDIATRICS 6.480,289 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0 6.480,289 0	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0167	From 01/01/2017	Part I Date/Time Pre	
Cost Center Description Total Cost (from Wkst. B, Part I, col. Therapy Limit Adj. Total Costs Disal Iowance Total Costs Total Costs 30.00 IMPATIENT ROUTINE SERVICE COST CENTERS 0.00 3.00 4.00 5.00 30.00 00000 (ADULTS & PEDIATRICS 0.000 (ADULTS & PEDIATRICS 6,480,289 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 6,480,289 0 1,270,035 0 1,270,035 0 1,270,035 1,270,035 1,270,035 1,270,035 1,270,037 0 693,701 6,03,701 6,03,701 6,03,701 6,03,701 6,03,701 6,03 0			Title	XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVICE COST CENTERS Adj. Di sal I owance Ji sal I owance 30.00 03000 ADULTS & PEDI ATRICS 6, 480, 289 0 6, 480, 289 0 6, 480, 289 0 6, 480, 289 30.00 4NCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 16, 038, 943 16, 038, 943 0 16, 038, 943 50.00 50.00 1270, 035 1, 270, 035 53.00 0 53.00 05000 OPERATI NG ROOM 16, 038, 943 16, 038, 943 0 16, 038, 943 50.00 50.00 1270, 035 53.00 0 1270, 035 53.00 0 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 62.00 60.00 62.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Part I, col. 26) 0 0 0 1000 2.00 3.00 4.00 5.00 0.00 03000 ADULTS & PEDIATRICS 6,480,289 6,480,289 0 6,480,289 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 (PERATI NG ROOM 16,038,943 16,038,943 0 6,480,289 50.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 62.00 60.00 62.00 60.00 62.00	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
26)			Adj.		Di sal I owance		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDI ATRI CS 6,480,289 6,480,289 0 6,480,289 30.00 ANCILLARY SERVI CE COST CENTERS							
INPATI ENT ROUTI NE SERVICE COST CENTERS Image: Cost Centers Imag							
30.00 AUULTS & PEDIATRICS 6, 480, 289 6, 480, 289 0 6, 480, 289 30.00 ANCILLARY SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 16,038,943 0 120,035 0 120,035 0 1,270,035 0 1,270,035 0 1,263,018 1,253,018 0 1,253,018 0 1,253,018 0 1,253,018 0 <t< td=""><td></td><td></td><td></td><td>(100 o</td><td></td><td>((00.000</td><td></td></t<>				(100 o		((00.000	
50.00 05000 0PERATI NG ROOM 16, 038, 943 16, 038, 943 0 16, 038, 943 50.00 53.00 05300 ANESTHESI OLOGY 1, 270, 035 1, 270, 035 0 1, 270, 035 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 136, 682 136, 682 0 136, 682 54.00 58.00 05800 MRI 1, 253, 018 1, 253, 018 0 1, 253, 018 0 1, 253, 018 0 693, 701 0 693, 701 0 693, 701 0 60.00 0 0 0 0 0 0 62.00 0 0 0 0 0 0 62.00 0 0 0 0 62.30 0 0 0 0 62.30 0 0 0 0 0 62.30 0 0 0 0 0 0 0 62.30 0 1, 416, 547 0 1, 416, 547 0 1, 416, 547 0 1, 416, 547 0 1, 416, 547 0 1, 332 69.00 0 0 0 0 <t< td=""><td></td><td>6, 480, 289</td><td></td><td>6, 480, 2</td><td>89 0</td><td>6, 480, 289</td><td>30.00</td></t<>		6, 480, 289		6, 480, 2	89 0	6, 480, 289	30.00
53.00 05300 ANESTHESI OLOGY 1, 270, 035 1, 270, 035 0 1, 270, 035 53.00 54.00 O5400 RADI OLOGY-DI AGNOSTI C 136, 682 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0 136, 682 0		14 000 040		1 4 4 4 4 4 4		11 000 010	
54.00 05400 RADI OLOGY-DI AGNOSTI C 136, 682 136, 682 0 136, 682 54.00 58.00 05800 MRI 1, 253, 018 1, 253, 018 0 1, 253, 018 58.00 60.00 06200 HABORATORY 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 693, 701 0 60.00 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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60.00 06000 LABORATORY 693, 701 693, 701 693, 701 60, 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 120,802 0 120,802 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,416,547 0 1,332 0 1,332 1,332 0 1,332 0 1,332 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 120,802 0 120,802 0 120,802 0 120,802 0 120,802 0 1,416,547 0 1,416,547 66.00 0 69.00 0 0 1,332 1,332 0 1,332 69.00 1,332 69.00 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 69.00 1,332 0 1,332 1,332 1,330 1,330 0 1,300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<							1
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 120,802 0 120,802 0 120,802 65.00 66.00 06600 PHYSICAL THERAPY 1,416,547 0 1,416,547 0 1,416,547 66.00 69.00 06900 ELECTROCARDIOLOGY 1,332 1,332 0 1,332 0 1,332 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4,270,570 4,270,570 0 4,270,570 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 26,995,278 26,995,278 26,995,278 20.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 2,679,966 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76.98 76.99 0 0 0 0 76.99 99.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00<		693, 701		693, /			
65.00 06500 RESPI RATORY THERAPY 120,802 0 120,802 0 120,802 65.00 66.00 06600 PHYSI CAL THERAPY 1,416,547 0 1,416,547 0 1,416,547 66.00 69.00 06900 ELECTROCARDI OLOGY 1,332 1,332 0 1,332 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4,270,570 4,270,570 0 4,270,570 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26,995,278 26,995,278 0 26,995,278 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2,679,966 0 2,679,966 73.00 76.97 07697 CARDI AC REHABILI TATI ON 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76.99 70.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 447,668 447,668 447,668 92.00 90.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 447,668 447,668 44		0			0 0		
66.00 06600 PHYSI CAL THERAPY 1,416,547 0 1,416,547 0 1,416,547 66.00 69.00 06900 ELECTROCARDI OLOGY 1,332 1,332 0 1,332 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 4,270,570 4,270,570 0 4,270,570 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 26,995,278 26,995,278 0 26,995,278 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2,679,966 2,679,966 0 2,679,966 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76.98 76.98 07699 LI THOTRI PSY 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 92.00 90.00 92.00 90.00 90.00 92.00 90.00 90.00 92.00 90.00		120,002	0	120.0		-	
69.00 06900 ELECTROCARDIOLOGY 1,332 1,332 1,332 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4,270,570 4,270,570 0 4,270,570 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 26,995,278 0 26,995,278 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 2,679,966 0 2,679,966 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76.98 07699 LITHOTRIPSY 0 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0 0 0 76.99 90.00 09000 CLINIC 0 0 0 0 90.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0				
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 270, 570 4, 270, 570 4, 270, 570 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26, 995, 278 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 0 0 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0 26, 995, 278 0			0				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 26,995,278 26,995,278 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 2,679,966 0 2,679,966 73.00 74.00 07407 CARDIA C REHABILITATION 0 0 0 0 73.00 76.97 07697 CARDIA C REHABILITATION 0 0 0 0 76.97 76.98 07699 LI THOTRIPSY 0 0 0 0 0 76.98 76.99 07699 LI THOTRIPSY 0 0 0 0 0 76.98 70.00 09000 CLINIC 0 0 0 0 76.99 00 09200 DSERVATION BEDS (NON-DI STINCT PART 447,668 447,668 447,668 92.00 90.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 447,668 447,668 447,668 92.00 90.00 09200 DABULATORY SURGICAL CENTER (D. P.) 15,635,223 15,635,223 15,635,223 15,635,223 15,00 115.00 Subtotal (see instructi							
73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 2,679,966 0 2,679,966 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 LITHOTRIPSY 0 0 0 0 76.98 70.00 07699 LITHOTRIPSY 0 0 0 0 76.98 70.00 09000 CLINIC 0 0 0 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 447,668 447,668 447,668 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 447,668 447,668 447,668 92.00 92.00 011500 AMBULATORY SURGICAL CENTER (D. P.) 15,635,223 15,635,223 15,635,223 15.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15,635,223 15,635,223 15.00 77,440,054 0 77,440,054 00.00 20.00 20.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
76. 97 07697 CARDI AC REHABILITATION 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 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90. 00 90. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 447, 668 447, 668 447, 668 92. 00 92. 00 OP2000 DBSERVATI ON BEDS (NON-DI STI NCT PART 447, 668 447, 668 92. 00 92. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 15, 635, 223 15. 635, 223 15. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 15, 635, 223 15. 635, 223 15. 00 200. 00 Subtotal (see instructions) 77, 440, 054 0 77, 440, 054 0 77, 440, 054 200. 00 201. 00 Less Observati on Beds 447, 668 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76. 98 76. 99 07699 L1 THOTRI PSY 0 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 90. 00 90. 00 09000 CLI NI C 0 0 0 90. 00 92. 00 092200 0BSERVATI ON BEDS (NON-DI STI NCT PART 447, 668 447, 668 447, 668 SPECIAL PURPOSE COST CENTERS 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 15, 635, 223 15, 635, 223 15. 00 200. 00 Subtotal (see instructions) 77, 440, 054 0 77, 440, 054 0 77, 440, 054 200. 00 201. 00 Less Observation Beds 447, 668 447, 668 241, 668 201. 00		2,077,700		2,017,7			
76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATI ENT SERVICE COST CENTERS 0 0 0 90.00 90.00 90.00 0 0 0 90.00 90.00 90.00 90.00 90.00 0 0 0 90.00 90.00 90.00 90.00 90.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 447,668 447,668 447,668 92.00 92.00 92.00 150.635,223 15,635,223 15.00 150.03 447,668 92.00		0			0 0		
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.00 92.00 092000 0BSERVATION BEDS (NON-DISTINCT PART 447,668 447,668 447,668 92.00 SPECIAL PURPOSE COST CENTERS 15,635,223 15,635,223 15,635,223 15,635,223 115.00 115.00 Subtotal (see instructions) 77,440,054 0 77,440,054 0 77,440,054 200.00 201.00 Less Observation Beds 447,668 447,668 201.00		0			0 0		
90. 00 09000 CLINIC 0 0 0 0 90. 00 90.				1			/0. //
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 447,668 447,668 447,668 92. 00 SPECIAL PURPOSE COST CENTERS 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 15,635,223 15,635,223 15,635,223 15.00 115.00 200.00 Subtotal (see instructions) 77,440,054 0 77,440,054 0 77,440,054 200.00 201.00 247,668 2417,668 2417,668 201.00 <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>90.00</td>		0			0 0	0	90.00
SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 15, 635, 223 <td></td> <td></td> <td></td> <td>447 6</td> <td>0</td> <td>-</td> <td></td>				447 6	0	-	
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 15, 635, 223 15,		,000		,0		, 000	1
200. 00 Subtotal (see instructions) 77, 440, 054 0 77, 440, 054 0 77, 440, 054 200. 00 201. 00 Less Observation Beds 447, 668 447, 668 447, 668 201. 00		15, 635, 223		15, 635, 2	23	15, 635, 223	1115.00
201.00 Less Observation Beds 447, 668 447, 668 447, 668 201.00							
202. UU TUTAT (SEE THE TUCTIONS) TO TO, 442, 300 UT 70, 442, 300 UT 70, 442, 300 UT 70, 442, 300 UT 70, 442, 300	202.00 Total (see instructions)	76, 992, 386					

Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 7:4	
			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	0.000.440		0.000.00			
30. 00 03000 ADULTS & PEDIATRICS	8, 292, 442		8, 292, 44	2		30.00
ANCI LLARY SERVI CE COST CENTERS		77 000 075	4/0 700 07	0 0 007054	0.000000	
50. 00 05000 OPERATING ROOM	86, 709, 895	77, 029, 975			0.00000	
53. 00 05300 ANESTHESI OLOGY	7, 681, 829	6, 172, 321			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 396, 531	1, 896, 265			0.00000	
58. 00 05800 MRI	34, 189	9,010,292				
60. 00 06000 LABORATORY	1, 910, 203	285, 168	2, 195, 37			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0. 000000		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	107.0/	0 0. 000000		
65. 00 06500 RESPIRATORY THERAPY	119, 613	17, 755			0.00000	
66.00 06600 PHYSI CAL THERAPY	3, 903, 018	44, 176				
69.00 06900 ELECTROCARDI OLOGY	32, 033	55, 384			0.00000	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	9, 662, 712	9, 980, 385				•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	81, 108, 903	19, 413, 015			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 836, 133	5, 687, 903	18, 524, 03			
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0. 000000		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0. 000000		
76. 99 07699 LI THOTRI PSY	0	0		0 0. 000000	0. 000000	76.99
		0		0 0 00000	0,000000	00.00
90.00 09000 CLINIC	0	0		0 0.00000		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	309, 146	309, 14	6 1. 448080	0. 000000	92.00
SPECIAL PURPOSE COST CENTERS		05 014 000	05 214 00	2		115 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	85, 314, 003				115.00
200.00 Subtotal (see instructions)	213, 687, 501	215, 215, 788	428, 903, 28	7		200.00
201.00 Less Observation Beds	212 (07 501	01E 01E 700	420,002,20	0		201.00
202.00 Total (see instructions)	213, 687, 501	215, 215, 788	428, 903, 28	7		202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 7:4	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 097954				50.00
53. 00 05300 ANESTHESI OLOGY	0. 091672				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 041509				54.00
58. 00 05800 MRI	0. 138540				58.00
60. 00 06000 LABORATORY	0. 315983				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 879404				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 358874				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 015237				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217408				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 268551				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 144675				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76.98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 448080				92.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	ORTHOPAEDI C HOSF	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 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 7:4	
		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)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 480, 289		6, 480, 2	89 0	6, 480, 289	30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	16, 038, 943		16, 038, 9		16, 038, 943	
53.00 05300 ANESTHESI OLOGY	1, 270, 035		1, 270, 0		1, 270, 035	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	136, 682		136, 6		136, 682	
58.00 05800 MRI	1, 253, 018		1, 253, 0		1, 253, 018	
60. 00 06000 LABORATORY	693, 701		693, 7	01 0	693, 701	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	120, 802	C	120, 8		120, 802	
66. 00 06600 PHYSI CAL THERAPY	1, 416, 547	C	1, 416, 5		1, 416, 547	
69.00 06900 ELECTROCARDI OLOGY	1, 332		1, 3		1, 332	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 270, 570		4, 270, 5		4, 270, 570	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 995, 278		26, 995, 2		26, 995, 278	1
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 679, 966		2, 679, 9	66 0	2, 679, 966	
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			
90. 00 09000 CLINIC	0			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	447, 668		447,6	68	447, 668	92.00
SPECIAL PURPOSE COST CENTERS	15 (05 000)		15 (05 0	<u></u>	45 (05 000	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	15, 635, 223	-	15, 635, 2		15, 635, 223	
200.00 Subtotal (see instructions)	77, 440, 054	C	11111010		77, 440, 054	
201.00 Less Observation Beds	447,668	-	447,6		447, 668	
202.00 Total (see instructions)	76, 992, 386	C	76, 992, 3	86 0	76, 992, 386	202.00

62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0.000000 0.000000 62.0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0.000000 62.3 65.00 06500 RESPIRATORY THERAPY 119,613 17,755 137,368 0.879404 0.000000 65.0 66.00 06600 PHYSICAL THERAPY 3,903,018 44,176 3,947,194 0.358874 0.000000 69.0 69.00 06900 ELECTROCARDIOLOGY 32,033 55,384 87,417 0.015237 0.000000 69.0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9,662,712 9,980,385 19,643,097 0.217408 0.000000 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 81,108,903 19,413,015 100,521,918 0.268551 0.000000 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 12,836,133 5,687,903 18,524,036 0.446055 0.000000 73.0	Health Financial Systems	ORTHOPAEDI C HOSP	T. AT PARKVIEW		In Lie	eu of Form CMS-:	2552-10
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost of ther Ratio TEFRA Inpatient Ratio 30.00 03000 ADULTS & PEDIATRICS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 8.292,442 8.292,442 30.0 ANCILLARY SERVICE COST CENTERS 9.00 10.00 50.00 05300 ARESTHESI 0LOGY 7.681,829 6.172,321 13.854,150 0.097954 0.000000 58.0 50.00 05400 RADIOLOGY DI AGNOSTI C 1,396,531 1,896,265 3,292,796 0.041509 0.000000 58.00 0.000000 58.00 0.000000 58.00 0.000000 58.00 0.000000 58.00 0.000000 68.00 0.000000 68.00 0.000000 68.00 0.000000 68.00 62.00 0.000000 62.00 0.000000 62.00 0.000000 62.00 0.000000 62.00 0.000000 62.00 0.000000 62.00 0.000000 62.00 66.00 0.000000 62.00 66.00 0.0000000 62.00 66.00	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/30/2018 7:4	
Cost Center Description Inpatient Outpatient Total (col. 6 + col. 7) Cost or Other Ratio TEFRA Inpatient Ratio 30.00 03000 ADULTS & PEDI ATRI CS 8.292,442 8.292,442 30.00 ANCI LLARY SERVICE COST CENTERS 8.292,442 8.292,442 30.00 50.00 05000 OPERATI NG ROM 86,709,895 77,029,975 163,739,870 0.097954 0.000000 53.00 53.00 05400 RADI OLOGY 7,681,829 6,172,321 13,854,150 0.091672 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,396,531 1,896,265 3.292,796 0.041509 0.000000 58.00 060.00 LABORATORY 1,910,203 285,168 2,195,371 0.315983 0.000000 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 62.03 0.05800 RESPI RATORY THERAPY 119,613 17,755 137,368 0.879404 0.00000 62.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00				e XIX	Hospi tal	PPS	
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66. 00 06600 PHYSI CAL THERAPY 3, 903, 018 44, 176 3, 947, 194 0. 358874 0. 000000 66. 0 69. 00 06900 ELECTROCARDI OLOGY 32, 033 55, 384 87, 417 0. 015237 0. 000000 69. 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 9, 662, 712 9, 980, 385 19, 643, 097 0. 217408 0. 000000 71. 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 81, 108, 903 19, 413, 015 100, 521, 918 0. 268551 0. 000000 72. 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 81, 108, 903 19, 413, 015 100, 521, 918 0. 268551 0. 000000 72. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 76. 9 76. 99 07699 LI THOTRI PSY 0 0 0 0. 000000 76. 9 76. 99 07699 LI THOTRI PSY 0 0 0 0. 000000 76. 9		0	0				
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72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 81, 108, 903 19, 413, 015 100, 521, 918 0. 268551 0. 000000 72. 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 12, 836, 133 5, 687, 903 18, 524, 036 0. 144675 0. 000000 73. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0.000000 76. 9 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0.000000 76. 9 76. 99 07699 LI THOTRI PSY 0 0 0 0.000000 76. 9							
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76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 76. 9 76. 99 07699 LI THOTRI PSY 0 0 0 0.000000 76. 9		12, 836, 133	5, 687, 903	18, 524, 03	6 0. 144675	0. 000000	
76. 99 0 0 0 0.000000 76. 9	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0. 000000	76.97
	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				
	76. 99 07699 LI THOTRI PSY	0	0		0.000000	0.00000	76.99
	OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 0 0 0. 000000 90. 0	90. 00 09000 CLINIC	0	0		0.000000	0.000000	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 309, 146 1. 448080 0. 000000 92. 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	309, 146	309, 14	6 1. 448080	0.000000	92.00
SPECIAL PURPOSE COST CENTERS	SPECIAL PURPOSE COST CENTERS						
	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	85, 314, 003	85, 314, 00	3		115.00
	200.00 Subtotal (see instructions)	213, 687, 501	215, 215, 788	428, 903, 28	9	ł	200.00
201.00 Less Observation Beds 201.0	201.00 Less Observation Beds					ł	201.00
202. 00 Total (see instructions) 213, 687, 501 215, 215, 788 428, 903, 289 202. 0	202.00 Total (see instructions)	213, 687, 501	215, 215, 788	428, 903, 28	9	ł	202.00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVI EW	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 7:4	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 OPERATING ROOM	0. 097954				50.00
53.00 05300 ANESTHESI OLOGY	0. 091672				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 041509				54.00
58.00 05800 MRI	0. 138540				58.00
60. 00 06000 LABORATORY	0. 315983				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62.30
65. 00 06500 RESPI RATORY THERAPY	0. 879404				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 358874				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 015237				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217408				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 268551				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 144675				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99 07699 LI THOTRI PSY	0. 000000				76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 448080				92.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAL DIONLY Provider CCN: 15-0167 Period: From 01/01/2017 To 12/31/2017 Worksheet C Date/Time Prepared: Date/Time Prepared: Date/Time Prepared: Cost Center Description Worksheet C Total Cost Cost Center Description Total Cost (Wst. B, Part Net of Capital I, col. 26) Title XIX Hospital Period: Descriptial Period: Period: Total Cost Period: From 01/01/2017 Period: Total Cost ANCILLARY SERVICE COST CENTERS Total Cost I, col. 26) Capital Cost I, 200 Cost Center Description Reduction Amount MOLLLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATIESI OLOGY 1.270,035 27,944 1,457,337 14,581,606 0 0 58.00 50.00 05000 ANESTHESI OLOGY 1.253,018 205,981,1047,030 0 58.00 58.00 60.00 06000 LABORATORY ERD BLOOD CELL 0	Health Financial Systems	ORTHOPAEDI C HOSF	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
Cost Center Description Total Cost (Wkst. B, Part (Wst. B, PartNet of Capital I, col. 26) Capital Cost (Col. 1, col. 2) Capital Reduction Operating Cost Reduction ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05300 (DPERATING ROOM 16,038,943 1.457,337 14,581,606 0 0 50.00 54.00 05300 (AVESTHESIOLOGY 1.270,035 27,944 1,242,091 0 0 53.00 54.00 05600 (MR) 16,038,943 1,457,337 14,581,606 0 0 54.00 60.00 066000 [LABORATORY 0 0 0 0 54.00 62.00 066000 [LABORATORY 693,701 15,263 678,438 0 0 60.00 62.30 06500 RESPI RATORY THERAPY 120,802 2,658 118,144 0 0 659.00 64.00 06900 [ELECTROCARDIOLOGY 1,332 29 1,303 0 66.00 65.00 06500 [ESPI RATORY THERAPY 1,416,547 58,741 <td< td=""><td></td><td>ATIOS NET OF</td><td>Provider C</td><td>CN: 15-0167</td><td>From 01/01/2017</td><td>Part II Date/Time Pre</td><td></td></td<>		ATIOS NET OF	Provider C	CN: 15-0167	From 01/01/2017	Part II Date/Time Pre	
ANCI LLARY SERVICE COST CENTERS (Wkst. B, Part (Wkst. B, Part Net of Capital I, col. 26) Reduction Reduction 50.00 05000 0PERATING ROOM 1.00 2.00 3.00 4.00 50.00 50.00 05000 0PERATING ROOM 16,038,943 1,457,337 14,581,606 0 0 53.00 53.00 05300 ANESTHESI OLOGY 1,270,035 27,944 1,242,091 0 53.00 54.00 05400 RADICUGY-DI AGNOSTI C 136,682 3.007 133,475 0 0 58.00 60.00 060200 HOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 663,701 15,263 678,438 0 0 62.00 0 0 0 62.00 0			Titl	e XIX	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS (Wkst. B, Part (Wkst. B, Part (Cell coll coll coll coll coll coll coll c	Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
Image: Note of the image: No		(Wkst. B, Part					
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 16,038,943 1.457,337 14,581,606 0 0 50.00 53.00 05300 ANESTHESI OLOGY 1,270,035 27,944 1,242,091 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 136,682 3,007 133,675 0 0 54.00 58.00 05200 MRI 1,253,018 205,988 1,047,030 0 0 58.00 60.00 66000 LABORATORY 693,701 15,263 678,438 0 60.00 62.00 62.30 0.6500 RESPI RATORY THERAPY 120,802 2,658 118,144 0 65.00 66.00 06600 DeGOD ELECTROCARDI OLOGY 1,332 29 1,303 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2,679,966 96,844 2,583,122 0 <td></td> <td>I, col. 26)</td> <td>II col. 26)</td> <td>Cost (col. 1</td> <td>-</td> <td>Amount</td> <td></td>		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROM 16,038,943 1,457,337 14,581,606 0 0 50.00 53. 00 05300 ANESTHESI OLOGY 1,270,035 27,944 1,242,091 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 136,682 3,007 133,675 0 0 54.00 58. 00 05800 MR 1,253,018 205,998 1,047,030 0 58.00 60.00 CABORATORY 693,701 15,263 678,438 0 0 60.00 62.00 62200 WHOLE BLODD & PACKED RED BLOOD CELL 0 0 0 0 62.30 62250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 0 0 0 66.00 66.00 66.00 66.00 66.00 67.00 0 71.00 0 0 66.00<				col. 2)			
50.00 OS000 OPERATI NG ROOM 16,038,943 1,457,337 14,581,606 0 0 50.00 53.00 OS300 ANESTHESI OLOGY 1,270,035 27,944 1,242,091 0 0 53.00 54.00 OS400 RADI OLOGY-DI AGNOSTI C 136,682 3,007 133,675 0 0 58.00 60.00 D6000 LABORATORY 693,701 15,263 678,438 0 60.00 62.00 06200 WHOLE BLOOD CLUTTING FOR HEMOPHILIACS 0 0 0 62.00 0 0 0 0 0 0 0 62.00 0 0 62.00 0 0 0 0 0 0 0 62.00 65.00 66.00 67.00 0 67.00 0 71.00 71.00 7		1.00	2.00	3.00	4.00	5.00	
53.00 05300 ANESTHESI OLOGY 1, 270, 035 27, 944 1, 242, 091 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 136, 682 3, 007 133, 675 0 0 54.00 58.00 05800 MRI 1, 253, 018 205, 988 1, 047, 030 0 0 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 62.00 65.00 06500 RESPI RATORY 120, 802 2, 658 118, 144 0 0 62.30 66.00 06600 PHYSI CAL THERAPY 1, 416, 547 58, 741 1, 357, 806 0 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 1, 332 29 1, 303 0 672.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 2, 679, 966 96, 844 2, 583, 122 0 73.00 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 679, 966 96, 844 2, 583, 122 0 73.00 73.00 </td <td>ANCILLARY SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C 136, 682 3, 007 133, 675 0 0 54.00 58.00 05800 MRI 1, 253, 018 205, 988 1, 047, 030 0 658.00 60.00 LABORATORY 693, 701 15, 263 678, 438 0 0 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 64.00 06250 BLOOD CLOTTI NG FOR HEMOPHI LLACS 0 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 120, 802 2, 658 118, 144 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 416, 547 58, 741 1, 357, 806 0 66.00 69.00 06600 ELECTROCARDI OLOGY 1, 332 29 1, 303 0 67.00 67.00 71.00 07100 IMPL DEV. CHARGED TO PATI ENT 4, 270, 570 93, 948 26, 401, 330 0 0 73.00 73.00 73.00 73.00 73.00 73.00 74.97 74.97 649, 95, 278 593, 948 </td <td>50. 00 05000 OPERATI NG ROOM</td> <td>16, 038, 943</td> <td>1, 457, 337</td> <td>14, 581, 60</td> <td>0 0</td> <td>0</td> <td>50.00</td>	50. 00 05000 OPERATI NG ROOM	16, 038, 943	1, 457, 337	14, 581, 60	0 0	0	50.00
58.00 05800 MRI 1, 253, 018 205, 988 1, 047, 030 0 58.00 60.00 06000 LABORATORY 693, 701 15, 263 678, 438 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 62.00 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHILIACS 0 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 120, 802 2, 658 118, 144 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 416, 547 58.741 1, 357, 806 0 66.00 69.00 OTIOD MEDI CAL SUPPLIES CHARGED TO PATI ENT 4, 270, 570 93, 963 4, 176, 607 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26, 6995, 278 593, 948 26, 401, 330 0 72.00 73.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0 0 <t< td=""><td>53.00 05300 ANESTHESI OLOGY</td><td>1, 270, 035</td><td>27, 944</td><td>1, 242, 09</td><td>91 0</td><td>0</td><td>53.00</td></t<>	53.00 05300 ANESTHESI OLOGY	1, 270, 035	27, 944	1, 242, 09	91 0	0	53.00
60.00 06000 LABORATORY 693, 701 15, 263 678, 438 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 62.00 62.00 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0	54.00 05400 RADI OLOGY-DI AGNOSTI C	136, 682	3, 007	133, 67	75 0	0	54.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0	58.00 05800 MRI	1, 253, 018	205, 988	1, 047, 03	30 0	0	58.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 62. 30 65. 00 06500 RESPIRATORY THERAPY 120, 802 2, 658 118, 144 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 416, 547 58, 741 1, 357, 806 0 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 332 29 1, 303 0 67. 00 67. 00 0 71. 00 07100 MEDI CAL SUPLIES CHARGED TO PATI ENT 4, 270, 570 93, 963 4, 176, 607 0 0 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 26, 995, 278 593, 948 26, 401, 330 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 0 0 0 73. 00 73. 00 74. 97 CARDI AC REHABI LI TATI ON 0 0 0 0 73. 00 73. 00 76. 97 76. 98 976. 99 0 0 0 0 0 0 0 76. 98 76. 99 0 0 0 0 0 0 </td <td>60. 00 06000 LABORATORY</td> <td>693, 701</td> <td>15, 263</td> <td>678, 43</td> <td>38 0</td> <td>0</td> <td>60.00</td>	60. 00 06000 LABORATORY	693, 701	15, 263	678, 43	38 0	0	60.00
65.00 06500 RESPI RATORY THERAPY 120,802 2,658 118,144 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,416,547 58,741 1,357,806 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 1,332 29 1,303 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4,270,570 93,963 4,176,607 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26,995,278 593,948 26,401,330 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2,679,966 96,844 2,583,122 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 76.99 00 07699 LI THOTRI PSY 0 0 0 0 0 92.00 92.00 92.00 09	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
66.00 06600 PHYSI CAL THERAPY 1,416,547 58,741 1,357,806 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 1,332 29 1,303 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 4,270,570 93,963 4,176,607 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 593,948 26,401,330 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 96,844 2,583,122 0 0 73.00 76.97 7697 CARDI AC REHABILI TATION 0 0 0 0 76.97 76.98 07699 LI THOTRI PSY 0 0 0 0 76.97 76.99 07697 CARDI AC REHABILI TATION 0 0 0 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0 0 90.00 92.00 90.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 447,668 <td>62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>62.30</td>	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
69.00 06900 ELECTROCARDIOLOGY 1,332 29 1,303 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 4,270,570 93,963 4,176,607 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 593,948 26,401,330 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 96,844 2,583,122 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 76.97 76.99 01700 0 0 0 0 0 0 76.97 76.99 01700 00 0 0 0 0 90.00 90.00 92.00 90.00 09000 CLINIC 0 0 0 0 90.00 92.00 92.00 0BSERVATION BEDS (NON-DI STINCT PART 447,668 48,213 3	65. 00 06500 RESPI RATORY THERAPY	120, 802	2, 658	118, 14	14 0	0	65.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 4, 270, 570 93, 963 4, 176, 607 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 26, 995, 278 593, 948 26, 401, 330 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 679, 966 96, 844 2, 583, 122 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 76.98 90.00 09000 CLI NI C 0 0 0 0 90.00 9200 085ERVATI ON BEDS (NON-DI STI NCT PART 447, 668 48, 213 399, 455 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 15, 635, 223 501, 792 15, 133, 431 0 0 200.00 <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>1, 416, 547</td> <td>58, 741</td> <td>1, 357, 80</td> <td>06 0</td> <td>0</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	1, 416, 547	58, 741	1, 357, 80	06 0	0	66.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26,995,278 593,948 26,401,330 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 96,844 2,583,122 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.98 76.99 01700 0 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 70.00 09000 CLI NI C 0 0 0 0 0 90.00 90.00 090200 DBSERVATI ON BEDS (NON-DI STINCT PART 447, 668 48, 213 399, 455 0 0 92.00 SPECIAL PURPOSE COST CENTERS 115.00 Instor AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 501, 792 15, 133, 431 0 0 200.00 200.00 Less Observation Beds </td <td>69. 00 06900 ELECTROCARDI OLOGY</td> <td>1, 332</td> <td>29</td> <td>1, 30</td> <td>03 0</td> <td>0</td> <td>69.00</td>	69. 00 06900 ELECTROCARDI OLOGY	1, 332	29	1, 30	03 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 2,679,966 96,844 2,583,122 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.98 70.00 09000 CLI NI C 0 0 0 0 0 90.00 90.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 447,668 48,213 399,455 0 92.00 92.00 DSERVATI ON SEDS COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15,635,223 501,792 15,133,431 0 0 200.00 200.00 Less Observation Beds 447,668 48,213 399,455 0 0 200.00 201.00 Less Observation Beds <td< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT</td><td>4, 270, 570</td><td>93, 963</td><td>4, 176, 60</td><td>07 0</td><td>0</td><td>71.00</td></td<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 270, 570	93, 963	4, 176, 60	07 0	0	71.00
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 0 76. 98 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76. 99 0000 0000 CLI NI C 0 0 0 0 0 90. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 447, 668 48, 213 399, 455 0 92. 00 92. 00 0 DI 1500 AMBULATORY SURGI CAL CENTER (D. P.) 15, 635, 223 501, 792 15, 133, 431 0 0 115. 00 200. 00 Less Observati on Beds 447, 668 48, 213 399, 455 0 0 200. 00 201. 00 Less Observati on Beds 447, 668 48, 213 39	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 995, 278	593, 948	26, 401, 33	30 0	0	72.00
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 76. 98 00 0000 CLI NI C 0 0 0 0 90. 00 90. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 447, 668 48, 213 399, 455 0 92. 00 92. 00 SPECI AL PURPOSE COST CENTERS 155, 635, 223 501, 792 15, 133, 431 0 0 115. 00 200. 00 Subtotal (sum of lines 50 thru 199) 70, 959, 765 3, 105, 727 67, 854, 038 0 0 200. 00 201. 00 Less Observation Beds 447, 668 48, 213 399, 455 0 0 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	2, 679, 966	96, 844	2, 583, 12	22 0	0	73.00
76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 92.00 92.00 95.00 0 0 0 92.00 9	76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0 0 0 90.00 92.00 09200 0BSERVATI ON_BEDS_(NON-DI STINCT_PART 447,668 48,213 399,455 0 0 92.00 92.01 SPECIAL_PURPOSE_COST_CENTERS 501,792 15,133,431 0 0 115.00 115.00 AMBULATORY SURGICAL CENTER (D. P.) 15,635,223 501,792 15,133,431 0 0 115.00 200.00 Subtotal (sum of lines 50 thru 199) 70,959,765 3,105,727 67,854,038 0 0 200.00 201.00 Less Observation Beds 447,668 48,213 399,455 0 0 201.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 90. 00 92. 0	76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 447,668 48,213 399,455 0 0 92. 00 SPECIAL PURPOSE COST CENTERS 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 15,635,223 501,792 15,133,431 0 0 115. 00 200. 00 Subtotal (sum of Lines 50 thru 199) 70,959,765 3,105,727 67,854,038 0 0 200. 00 201. 00 Less Observation Beds 447,668 48,213 399,455 0 0 201. 00							
SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 501, 792 15, 133, 431 0 0 115.00 200.00 Subtotal (sum of Lines 50 thru 199) 70, 959, 765 3, 105, 727 67, 854, 038 0 0 200.00 201.00 Less Observation Beds 447, 668 48, 213 399, 455 0 0 201.00	90. 00 09000 CLINIC	0	0		0 0	0	90.00
115.00 AMBULATORY SURGICAL CENTER (D. P.) 15, 635, 223 501, 792 15, 133, 431 0 0 115.00 200.00 Subtotal (sum of Lines 50 thru 199) 70, 959, 765 3, 105, 727 67, 854, 038 0 0 200.00 201.00 Less Observation Beds 447, 668 48, 213 399, 455 0 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	447, 668	48, 213	399, 45	55 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199) 70,959,765 3,105,727 67,854,038 0 0 200.00 201.00 Less Observation Beds 447,668 48,213 399,455 0 0 201.00	SPECIAL PURPOSE COST CENTERS						
201.00 Less Observation Beds 447, 668 48, 213 399, 455 0 0 0 201.00	115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	15, 635, 223	501, 792	15, 133, 43	31 0	0	115.00
	200.00 Subtotal (sum of lines 50 thru 199)	70, 959, 765	3, 105, 727	67, 854, 03	38 0	0	200. 00
202.00 Total (line 200 minus line 201) 70, 512, 097 3, 057, 514 67, 454, 583 0 0 202.00	201.00 Less Observation Beds	447, 668	48, 213	399, 45	55 0	0	201.00
	202.00 Total (line 200 minus line 201)	70, 512, 097	3, 057, 514	67, 454, 58	33 0	0	202.00

Health Financial Systems	ORTHOPAEDI C HOSP	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE I REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Pre 5/30/2018 7:4	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpatient			
	Capital and	(Worksheet C,	Cost to Charg	ge		
	Operating Cost	Part I, column	Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	16, 038, 943	163, 739, 870	0. 09795	54		50.00
53. 00 05300 ANESTHESI OLOGY	1, 270, 035	13, 854, 150	0.0916	72		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	136, 682	3, 292, 796	0.04150)9		54.00
58. 00 05800 MRI	1, 253, 018	9,044,481	0. 13854	40		58.00
60. 00 06000 LABORATORY	693, 701	2, 195, 371	0. 31598	33		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	00		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00		62.30
65. 00 06500 RESPI RATORY THERAPY	120, 802	137, 368	0. 87940)4		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 416, 547	3, 947, 194	0. 3588	74		66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 332	87, 417	0. 01523	37		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 270, 570	19, 643, 097	0. 21740	08		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 995, 278	100, 521, 918	0. 2685	51		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 679, 966	18, 524, 036	0. 1446	75		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 CLI NI C	0	0	0.0000	00		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	447,668	309, 146	1.44808	30		92.00
SPECIAL PURPOSE COST CENTERS	·					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	15, 635, 223	85, 314, 003	0. 1832	57		115.00
200.00 Subtotal (sum of lines 50 thru 199)	70, 959, 765	420, 610, 847				200.00
201.00 Less Observation Beds	447,668	0				201.00
202.00 Total (line 200 minus line 201)	70, 512, 097	420, 610, 847				202.00

Health Financial Systems	ORTHOPAEDI C HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 0 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	697, 912	0	697, 91	2 5, 660	123. 31	30.00
200.00 Total (lines 30 through 199)	697, 912		697, 91	2 5,660		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 through 199)	1, 821 1, 821		1			30. 00 200. 00

Health Financial Systems	ORTHOPAEDIC 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 01/01/2017 To 12/31/2017		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	- F		1	- 1 .		
50.00 05000 OPERATING ROOM	1, 457, 337	163, 739, 870				
53. 00 05300 ANESTHESI OLOGY	27, 944			7 2, 448, 854	4, 939	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3,007	3, 292, 796	0. 00091	3 444, 094	405	54.00
58. 00 05800 MRI	205, 988	9, 044, 481	0. 02277	5 14, 561	332	58.00
60. 00 06000 LABORATORY	15, 263	2, 195, 371	0. 00695	2 689, 326	4, 792	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	2,658	137, 368	0. 01934	9 5, 111	99	65.00
66. 00 06600 PHYSI CAL THERAPY	58, 741	3, 947, 194	0. 01488	2 1, 303, 240	19, 395	66.00
69.00 06900 ELECTROCARDI OLOGY	29	87, 417	0. 00033	2 30, 037	10	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	93, 963	19, 643, 097	0. 00478	4 3, 296, 693	15, 771	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	593, 948	100, 521, 918	0. 00590	9 25, 939, 510	153, 277	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	96, 844	18, 524, 036	0. 00522	8 3, 976, 690	20, 790	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			•	·		1
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	48, 213	309, 146	0. 15595	5 0	0	92.00
200.00 Total (lines 50 through 199)	2, 603, 935			62, 537, 418	436, 875	200 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0167 Period: From 01/01/2017 To 12/31/2017 Worksheet D Part III Date/Time Prepa 5/30/2018 7:40 Cost Center Description Nursing School Post-Stepdown Nursing School Post-Stepdown Allied Health Cost Allied Health Cost All Other Medical	
Cost Center Description Nursing School Nursing School Nursing School Allied Health Allied Health All Other Post-Stepdown Post-Stepdown Cost Medical	
Post-Stepdown Cost Medical	
Adjustments Adjustments Education Cost	
1A 1.00 2A 2.00 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
	30. 00
200.00 Total (lines 30 through 199) 0	00.00
Cost Center Description Swing-Bed Total Costs Total Patient Per Diem (col. Inpatient	
Adjustment (sum of cols. Days 5 ÷ col. 6) Program Days	
Amount (see 1 through 3,	
i nstructi ons) mi nus col. 4)	
4.00 5.00 6.00 7.00 8.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 0 5, 660 0. 00 1, 821 3	20.00
200.00 Total (Lines 30 through 199) 0 5,660 1,821 20	30.00
Cost Center Description Inpatient	<u>JO. 00</u>
Program	
Pass-Through	
Cost (col. 7 x)	
9.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 0 3	30. 00
200.00 Total (lines 30 through 199) 0 20	00.00

Health Financial Systems 0	RTHOPAEDI C HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS			Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 7:4	pared: 0 am
			e XVIII	Hospi tal	PPS	
Cost Center Description				I Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1	_		
50.00 05000 OPERATING ROOM	0	0		0 0	0	00.00
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 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0)	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	9	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00 05000 OPERATING ROOM	0	0		0 163, 739, 870		
53. 00 05300 ANESTHESI OLOGY	0	0		0 13, 854, 150		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 3, 292, 796		
58.00 05800 MRI	0	0		0 9, 044, 481		
60. 00 06000 LABORATORY	0	0		0 2, 195, 371		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.00000	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 137, 368		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 947, 194		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 87, 417		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 19, 643, 097		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 100, 521, 918		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 18, 524, 036		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0. 000000	
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS	1		1		I	
90. 00 09000 CLINIC	0	0		0 0	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 309, 146		
200.00 Total (lines 50 through 199)	0	0	1	0 335, 296, 844		200. 00

Health Financial Systems 0	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/30/2018 7:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			-		
50. 00 05000 OPERATI NG ROOM	0. 000000	24, 389, 302		0 11, 207, 171	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	2, 448, 854		0 922, 919	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	444, 094		0 374, 081	0	54.00
58. 00 05800 MRI	0. 000000	14, 561		0 1, 604, 415	0	58.00
60. 00 06000 LABORATORY	0. 000000	689, 326		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	5, 111		0 11, 494	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 303, 240		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	30, 037		0 3, 484	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 296, 693		0 1, 250, 591	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	25, 939, 510		0 3, 130, 880	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 976, 690		0 954, 004	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS	·				·	
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 34, 508	0	92.00
200.00 Total (lines 50 through 199)		62, 537, 418		0 19, 493, 547	0	200. 00

Health Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI EW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	
			Charges	-	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	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			1			
50. 00 05000 OPERATI NG ROOM	0. 097954			0 0	1, 097, 787	
53. 00 05300 ANESTHESI OLOGY	0. 091672			0 0	84, 606	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 041509			0 0	15, 528	
58.00 05800 MRI	0. 138540			0 0	222, 276	1
60. 00 06000 LABORATORY	0. 315983			0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0.879404			0 0	10, 108	65.00
66. 00 06600 PHYSI CAL THERAPY	0.358874	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 015237	3, 484		0 0	53	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217408	1, 250, 591		0 0	271, 888	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 268551	3, 130, 880		0 0	840, 801	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 144675	954, 004		0 0	138, 021	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. 448080	34, 508		0 0	49, 970	92.00
200.00 Subtotal (see instructions)		19, 493, 547		0 0	2, 731, 038	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		19, 493, 547		0 0	2, 731, 038	202.00

Health Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVI EW		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pro 5/30/2018 7:4	
			XVIII	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	I			
50. 00 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
58. 00 05800 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	T					
90. 00 09000 CLINIC	0	0				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	_	_				
202.00 Net Charges (line 200 - line 201)	0	0	1			202.00

Health Financial Systems	ORTHOPAEDIC HOSPT.AT PARKVIEW In Lieu of Form CMS					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 0 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)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	697, 912	C	697, 91	2 5, 660	123. 31	30.00
200.00 Total (lines 30 through 199)	697, 912		697, 91	2 5, 660		200.00
Cost Center Description	Inpatient Program days	Inpatient Program 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 through 199)	13 13					30. 00 200. 00

Health Financial Systems C	RTHOPAEDIC HOSI	PT. AT PARKVI EW		In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 457, 337	163, 739, 870			1, 703	
53. 00 05300 ANESTHESI OLOGY	27, 944	13, 854, 150	0. 00201	7 21, 810	44	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3,007	3, 292, 796	0. 00091	3 2, 979	3	54.00
58. 00 05800 MRI	205, 988	9, 044, 481	0. 02277	5 0	0	58.00
60. 00 06000 LABORATORY	15, 263	2, 195, 371	0. 00695	2 8, 105	56	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	2,658	137, 368	0. 01934	9 2, 584	50	65.00
66. 00 06600 PHYSI CAL THERAPY	58, 741	3, 947, 194	0. 01488	2 7, 928	118	66.00
69. 00 06900 ELECTROCARDI OLOGY	29	87, 417	0. 00033	2 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	93, 963	19, 643, 097	0. 00478	4 25, 722	123	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	593, 948	100, 521, 918	0. 00590	9 156, 541	925	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	96, 844	18, 524, 036	0. 00522	8 38, 115	199	73.00
76. 97 07697 CARDI AC REHABILI 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	·	-	•		·	1
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	48, 213	309, 146	0. 15595	5 0	0	92.00
200.00 Total (lines 50 through 199)	2, 603, 935	335, 296, 844		455, 127	3 221	200.00

	ORTHOPAEDIC HOS			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider CO		Period: From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Healt	Allied Health	All Other	
	Post-Stepdown	-	Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien ⁻	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	-			
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 66	0.00	13	30.00
200.00 Total (lines 30 through 199)		0	5, 66	0	13	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	7 Peri od: From 01/01/20 To 12/31/20 Hospi tal		
Cost Center Description Non Physician Nursing School Nursing S Anesthetist Post-Stepdown Adjustments 1.00 2A 2.00 ANCI LLARY SERVICE COST CENTERS 0 0	Hospi tal	5/ 50/ 2010 7.4	
Anesthetist Post-Stepdown Cost Adjustments 1.00 2A 2.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0	nospitai	PPS	
Cost Adjustments 1.00 2A 2.00 ANCI LLARY SERVICE COST CENTERS 0 0	School Allied Heal	th Allied Health	
1.00 2A 2.00 ANCI LLARY SERVICE COST CENTERS 0 0	Post-Stepdo	vn	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0 0	Adj ustment		
50. 00 05000 OPERATI NG ROOM 0 0) 3A	3.00	
	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 IMPL. DEV. CHARGED TO PATIENTS 0 0	0	0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0	0	0 0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0	0	0 0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0	0	0 0	76.98
76. 99 07699 LI THOTRI PSY 0 0	0	0 0	76.99
OUTPATIENT SERVICE COST CENTERS		-	1
90. 00 09000 CLINIC 0 0	0	0 0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0	0	0	92.00
200.00 Total (lines 50 through 199) 0 0	-		200.00

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVI EW				2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8 k	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1	T		
50. 00 05000 OPERATI NG ROOM	0	C		0 163, 739, 870		
53. 00 05300 ANESTHESI OLOGY	0	C		0 13, 854, 150		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 3, 292, 796		
58. 00 05800 MRI	0	C		0 9, 044, 481		
60. 00 06000 LABORATORY	0	0		0 2, 195, 371		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0. 000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 137, 368		
66. 00 06600 PHYSI CAL THERAPY	0	C		0 3, 947, 194		
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 87, 417	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 19, 643, 097	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 100, 521, 918	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 18, 524, 036	0.000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C)	0 0	0. 000000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C)	0 0	0. 000000	76. 98
76. 99 07699 LI THOTRI PSY	0	C)	0 0	0. 000000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0 0	0. 000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0 309, 146	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 335, 296, 844		200.00

Health Financial Systems C	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO		Period: From 01/01/2017	Worksheet D Part IV	
				To 12/31/2017	Date/Time Pre 5/30/2018 7:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			r	1		
50.00 05000 OPERATI NG ROOM	0. 000000	191, 343		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	21, 810		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 979		0 0	0	54.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	8, 105		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0.000000	2, 584		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	7, 928		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	25, 722		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	156, 541		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	38, 115		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		455, 127		0 0	0	200. 00

Health Financial Systems 0	RTHOPAEDI C HOSF	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/30/2018 7:4	
		Titl	e XIX	Hospi tal	PPS	
			Charges	_	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.007054					
50. 00 05000 OPERATI NG ROOM	0.097954	0		0 382, 199		
53. 00 05300 ANESTHESI OLOGY	0. 091672	0		0 30, 102		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 041509	0		0 6, 657	0	54.00
58. 00 05800 MRI	0. 138540	0		0 35, 231	0	58.00
60. 00 06000 LABORATORY	0. 315983	0		0 811	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 879404	0		0 458	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 358874	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 015237	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 217408	0		0 65, 670	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 268551	0		0 147, 820	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 144675	0		0 27, 158	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. 448080	0		0 1, 419	0	92.00
200.00 Subtotal (see instructions)		0	1	0 697, 525	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		0 697, 525	0	202.00

Health Financial Systems C	RTHOPAEDIC HOS	PT. AT PARKVI EW		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/30/2018 7:4	
	-		e XIX	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCI LLARY SERVI CE COST CENTERS	0.00	1.00	I			
50. 00 05000 OPERATI NG ROOM	0	37, 438				50.00
53.00 05300 ANESTHESI OLOGY	0	2,760				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	276				54.00
58.00 05800 MRI	0	4, 881				58.00
60. 00 06000 LABORATORY	0	256				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	403				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	14, 277				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	39, 697				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 929				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76.99
OUTPATIENT SERVICE COST CENTERS	1	1	1			_
90. 00 09000 CLINIC	0	-	1			90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	2, 055				92.00
200.00 Subtotal (see instructions)	0	105, 972				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		105 070				
202.00 Net Charges (line 200 - line 201)	0	105, 972				202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0167	Period: From 01/01/2017	Worksheet D-1	
			To 12/31/2017	Date/Time Prep 5/30/2018 7:40	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			5, 660 5, 660	1.00 2.00
. 00	Private room days (excluding swing-bed and observation bed day		rivate room days,	5, 660 0	3.00
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		5, 269	4.00
. 00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5.00
. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Docombo	r 21 of the cost	0	7.00
. 00	reporting period	in days) (Thi dugit becenibe	i si oi the cost	0	7.00
. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December :	31 of the cost	0	8.00
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	1, 821	9.00
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	0	10.00
1.00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			
2.00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	X only (including priva	te room days)	0	12.00
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ve			0	13.00
4.00	Medically necessary private room days applicable to the Progra			0	
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 (of the cost	0.00	17.00
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18.00
9. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	0.00	19.00
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20.00
1.00	reporting period Total general inpatient routine service cost (see instructions	s)		6, 480, 289	21.00
2.00	Swing-bed cost applicable to SNF type services through December	·	ting period (line	0, 400, 207	22.00
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23.00
4. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 21 of the cost roport	ing pariod (Lina	0	24.00
	7 x line 19)		51 (
5.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	25.00
6.00	Total swing-bed cost (see instructions)	(line 21 minus line 2()		0	26.00
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 MITHUS TTHE 26)		6, 480, 289	27.00
8.00	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	
9.00	Private room charges (excluding swing-bed charges)			0	29.00
0.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷ TTHE 28)		0.00000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lino 22) (cos instant	ctions)	0.00	
4.00	Average per diem private room charge differential (line 32 min			0.00	
5.00	Average per diem private room cost differential (line 34 x lin			0.00	
6.00 7.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	0 6, 480, 289	36.0 37.0
	27 minus line 36)			5, 100, 207	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 144. 93	38.00
8 ()()	a set a general inpatrient reactine set i ce cost per di elli (see	-			
8.00	Program general inpatient routine service cost (line 9 x line	38)	I	2.084 918	39.00
8.00 9.00 0.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			2, 084, 918 0	39.00 40.00

Heal th	Financial Systems C	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eriod:	Worksheet D-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	oared [.]
						5/30/2018 7:4	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Inpatrent Cost	inpatrent bays	col. 2)		(cor. 3 x cor. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
12 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	Line 200)			11, 582, 575	48.00
	Total Program inpatient costs (sum of lines			ns)		13, 667, 493	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	224, 548	50.00
51.00	<pre>III) Pass through costs applicable to Program inp and LVD</pre>	atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	436, 875	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				661, 423	52.00
	Total Program inpatient operating cost exclu		lated, non-phy	sician anesthe	tist, and	13, 006, 070	
	medical education costs (line 49 minus line						
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F 4 00
	Program discharges Target amount per discharge					0	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
	If line 53/54 is less than the lower of line				he amount by	0	61.00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	X					
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reportin	g period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			ust reporting		0	00.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost rep	orting period	0	67.00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
08.00	(line 13 x line 20)		ecember 31 01	the cost repor	ting period	0	08.00
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
	Program routine service cost (line 9 x line			2)			72.00
73.00	Medically necessary private room cost applic	able to Program	(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B, Pa	rt II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu						78.00
	Aggregate charges to beneficiaries for exces	• •			$a \downarrow i n a = 70$		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		UST THE TATION	(TTHE /8 minu	5 ITTE /9)		80. 00 81. 00
82.00	Inpatient routine service cost per drem rimi)				82.00
	Reasonable inpatient routine service costs (•				83.00
	Program inpatient ancillary services (see in		、 、				84.00
	Utilization review - physician compensation	•					85.00 86.00
00.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:						00.00
	Total observation bed days (see instructions)				391	87.00
	Adjusted general inpatient routine cost per		line 2)			1, 144. 93	
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				447, 668	89.00

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017		
		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	697, 912	6, 480, 289	0. 10769	8 447, 668	48, 213	90.00
91.00 Nursing School cost	0	6, 480, 289	0.00000	0 447, 668	0	91.00
92.00 Allied health cost	0	6, 480, 289	0.00000	0 447, 668	0	92.00
93.00 All other Medical Education	0	6, 480, 289	0. 00000	0 447, 668	0	93.00

	Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW CATION OF INPATIENT OPERATING COST Provider CCN: 15-0167 Period: From 01/C To 12/3		u of Form CMS-2 Worksheet D-1 Date/Time Prep	
	Title XIX Hospi		5/30/2018 7:40 PPS) am
	Cost Center Description	-	1.00	
	PART I - ALL PROVIDER COMPONENTS			
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)		5, 660	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5, 660	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room	days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)		5, 269	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of th	e cost	0	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the	cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	cost	0	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the	cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the c	ost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		-	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed newborn days)	and	13	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)		0	10.00
	through December 31 of the cost reporting period (see instructions)		_	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) December 31 of the cost reporting period (if calendar year, enter 0 on this line)	after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room day	s)	0	12.00
	through December 31 of the cost reporting period			40.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room day after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	s)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00 16.00
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 services through December 31 of the cost		0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost		0.00	19. 00
	reporting period			
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20. 00
21.00	Total general inpatient routine service cost (see instructions)		6, 480, 289	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (5×1) x line 17)	(line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	о	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period	(Lino	0	24.00
	7 x line 19)			
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (I x line 20)	ine 8	0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		6, 480, 289	27.00
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			32.00
33.00 34.00			0.00	33.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential	(line	6, 480, 289	37.00
07.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
0,100				
01100	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)		1, 144. 93	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1, 144. 93 14, 884 0	

Heal th	Financial Systems (ORTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	oared [.]
						5/30/2018 7:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
			inpatrent bays	col. 2)	-	(COL 3 X COL	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
42 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						42.00
	CORONARY CARE UNIT						43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	Line 200)			81, 689	48.00
	Total Program inpatient costs (sum of lines			ns)		96, 573	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine :	services (from	wkst. D, sum	of Parts I and	1, 603	50.00
51.00	<pre>III) Pass through costs applicable to Program inp cost up</pre>	atient ancillar	y services (fr	rom Wkst. D, su	um of Parts II	3, 221	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				4, 824	52.00
	Total Program inpatient operating cost exclu		lated, non-phy	sician anesthe	etist, and	91, 749	
	medical education costs (line 49 minus line						
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F 4 00
	Program discharges Target amount per discharge					0	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, u	pdated and con	npounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	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	61.00
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
00100	PROGRAM INPATIENT ROUTINE SWING BED COST		0110110)				00100
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			lost reporting		0	00.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line)	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost rep	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)				3 1	0	69.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	09.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	ost per diem (li					71.00
	Program routine service cost (line 9 x line		(1)	25)			72.00
73.00 74.00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•				73.00 74.00
75.00	Capital -related cost allocated to inpatient	•			art II, column		75.00
	26, line 45)		,				
	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	· · · · · · · · · · · · · · · · · · ·					77.00 78.00
	Aggregate charges to beneficiaries for exces		rovi der record	ls)			79.00
80.00	Total Program routine service costs for comp	• •		•	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I						82.00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83.00 84.00
	Utilization review - physician compensation		ns)				85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					0.01	07.00
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			391 1, 144. 93	87.00 88.00
	Observation bed cost (line 87 x line 88) (se	•)			447, 668	

Health Financial Systems C	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017		
		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	697, 912	6, 480, 289	0. 10769	8 447, 668	48, 213	90.00
91.00 Nursing School cost	0	6, 480, 289	0.00000	0 447, 668	0	91.00
92.00 Allied health cost	0	6, 480, 289	0.00000	0 447, 668	0	92.00
93.00 All other Medical Education	0	6, 480, 289	0. 00000	0 447, 668	0	93.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0167	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	parad
			10 12/31/2017	5/30/2018 7:4	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1		
30. 00 03000 ADULTS & PEDI ATRI CS			5, 489, 337		30.00
ANCI LLARY SERVI CE COST CENTERS					-
50. 00 05000 OPERATI NG ROOM		0. 09795			•
53.00 05300 ANESTHESI OLOGY		0. 0916			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 04150			•
58.00 05800 MRI		0. 13854		2, 017	
60. 00 06000 LABORATORY		0. 31598		217, 815	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 87940		4, 495	
66. 00 06600 PHYSI CAL THERAPY		0. 35887			•
69. 00 06900 ELECTROCARDI OLOGY		0. 01523			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21740			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 26855			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 14467		575, 328	•
76. 97 07697 CARDIAC REHABILITATION		0.0000		0	
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. 44808	30 0	0	92.00
200.00 Total (sum of lines 50 through 94 and	l 96 through 98)		62, 537, 418	11, 582, 575	200.00
201.00 Less PBP Clinic Laboratory Services-P	Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			62, 537, 418		202.00

Health Financial Systems ORTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	5/30/2018 7:4	pared:
	Titl	e XIX	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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			30, 606		30.00
ANCI LLARY SERVI CE COST CENTERS		1	1		
50. 00 05000 OPERATI NG ROOM		0.0979			
53. 00 05300 ANESTHESI OLOGY		0.0916			
54. 00 O5400 RADI OLOGY-DI AGNOSTI C		0.04150			
58. 00 05800 MRI		0. 1385		0	
60. 00 06000 LABORATORY		0. 3159			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.87940			
66. 00 06600 PHYSI CAL THERAPY		0.3588			66.00
69. 00 06900 ELECTROCARDI OLOGY		0.0152		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.2174			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2685			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1446			
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	00000	0	76.99
OUTPATIENT SERVICE COST CENTERS		0.0000			00.00
90. 00 09000 CLINIC		0.0000		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		1. 44808		01 (00	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			455, 127	81,689	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (IIne 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	455, 127		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	AT PARKVIEW Provider CCN: 15-0167	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-: Worksheet E Part A Date/Time Pre 5/30/2018 7:4	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00	DRG Amounts Other than Outlier Payments	ing prior to October 1	(aaa	0	
01	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to october i	,See	7, 958, 864	1.01
02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	2, 939, 698	1. 02
03	instructions) DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	0	1. 03
04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	on or after	0	1.04
	October 1 (see instructions)			00 500	
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			32, 583 0	
02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
00	Managed Care Simulated Payments			7, 737, 997	3.00
00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instru	uctions)	35.93	4.00
00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
	or before 12/31/1996. (see instructions)				
00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add	on to the cap	0.00	6.00
00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7.00
01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7.0
00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and octoonathic pro	arams for	0.00	8.00
00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	0.0
	1998), and 67 FR 50069 (August 1, 2002).				
01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.0
02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospi tal	0.00	8. 02
	under § 5506 of ACA. (see instructions)	/ · · · ·			
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	ies (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	0.00	10.00
1.00	FTE count for residents in dental and podiatric programs.				11.00
2.00	Current year allowable FTE (see instructions)				12.00
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye	ear ended on or after Ser	tember 30 1997		14.0
	otherwise enter zero.				
	Sum of lines 12 through 14 divided by 3.				15.0
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo				16.00
	Adjusted rolling average FTE count				18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4			0.000000	19.0
0. 00	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
2.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA		0	22.0 ⁴
3. 00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
4.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0.00	
	instructions)				
5.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
7.00	IME payments adjustment factor. (see instructions)			0. 000000	
3.00 3.01	IME add-on adjustment amount (see instructions)	-)		0	
9.00 9.00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)	·/		0	
9.00 9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)1)		0	
	Disproportionate Share Adjustment				1
0.00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (see instruc	ctions)		30.0
1.00	Percentage of Medicaid patient days (see instructions)				31.0
2.00 3.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	.)			32.00
	Disproportionate share adjustment (see instructions)	·/			34.0

ALCULA	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre	pare
				5/30/2018 7:4	
		Title XVIII	Hospital	PPS	
			Prior to 10/1 1.00	2.00	
	Jncompensated Care Adjustment				
1	Total uncompensated care amount (see instructions)		0	0	35.
1	Factor 3 (see instructions)		0.00000000	0. 00000000	35.
	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (see	e 0	0	35.
	instructions) Pro rata share of the hospital uncompensated care payment am	mount (see instructions)	0	0	35.
	Total uncompensated care (sum of columns 1 and 2 on line 35.	. ,	0	0	36.
	Additional payment for high percentage of ESRD beneficiary of				
	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.
	652, 682, 683, 684 and 685 (see instructions)				
	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.
1	instructions)				
	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGS 652, 682, 683, 684	0		41.
	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6		0.00		43
	instructions)		Ŭ		
1.00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0.000000		44
	days)				
	Average weekly cost for dialysis treatments (see instruction		0.00		45
	Total additional payment (line 45 times line 44 times line 4	41.01)	10 001 145		46
	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural bospitals	10, 931, 145		47 48
	only. (see instructions)	Silari Turai nospitars	0		40
				Amount	
				1.00	
	Total payment for inpatient operating costs (see instruction			10, 931, 145	
1	Payment for inpatient program capital (from Wkst. L, Pt. I a			875, 002	
1	Exception payment for inpatient program capital (Wkst. L, Pf			0	51
1	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	The 49 see Instructions).		0	52 53
	Special add-on payments for new technologies			0	54
	Islet isolation add-on payment			0	54
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55
	Cost of physicians' services in a teaching hospital (see int			0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 th	nrough 35).	0	57
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58
	Total (sum of amounts on lines 49 through 58)			11, 806, 147	
	Primary payer payments Tatal amount payable for program boneficieries (line 50 min)	ic line (0)		0 11, 806, 147	60 61
	Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	us i i ile 00)		1, 084, 384	
	Coinsurance billed to program beneficiaries			1, 004, 304	63
	Allowable bad debts (see instructions)			7, 271	
	Adjusted reimbursable bad debts (see instructions)			4, 726	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		7, 271	66
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10, 726, 489	67
1	Credits received from manufacturers for replaced devices for			0	68
	Outlier payments reconciliation (sum of lines 93, 95 and 96)).(For SCH see instructions	5)	0	69
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	stration) adjustment (notruption->	0	
	Rural Community Hospital Demonstration Project (§410A Demons	, ,	instructions)	0	70
	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	1		0	70 70
	Pioneer ACO demonstration payment adjustment amount (see ins	structions)		0	70
	HSP bonus payment HVBP adjustment amount (see instructions)	51 4011 0137		0	70
	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0	70
	HVBP payment adjustment amount (see instructions)			125, 282	
1	HRR adjustment amount (see instructions)			0	70
. 94	Tikk aujustilent allount (see mistructions)		1		

ALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/30/2018 7:4	
	Title	<u>XVIII</u>	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
D.96 Low volume adjustment for federal fiscal year (0	0	70
the corresponding federal year for the period p Low volume adjustment for federal fiscal year (the corresponding federal year for the period e	yyyy) (Enter in column O		0	0	70
D. 98 Low Volume Payment-3				0	
D. 99 HAC adjustment amount (see instructions)				0	
1.00 Amount due provider (line 67 minus lines 68 plus	s/minus lines 69 & 70)			10, 851, 771	
1.01 Sequestration adjustment (see instructions)				217, 035	
1.02 Demonstration payment adjustment amount after se	equestration			0	
2.00 Interim payments				10, 630, 104	
3.00 Tentative settlement (for contractor use only)				0	73
 Balance due provider/program (line 71 minus line 73) 	es 71.01, 71.02, 72, and			4, 632	74
5.00 Protested amounts (nonallowable cost report iter	ms) in accordance with			0	75
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through	96)	I			1
0.00 Operating outlier amount from Wkst. E, Pt. A, I				0	90
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	
.00 Operating outlier reconciliation adjustment amou	unt (see instructions)			0	
.00 Capital outlier reconciliation adjustment amoun				0	
.00 The rate used to calculate the time value of mo				0.00	
.00 Time value of money for operating expenses (see	3			0.00	
. 00 Time value of money for capital related expenses				0	
stor finite variation inforce for capital related expense.			Prior to 10/1		70
			11101 10 10/11		
			1.00	2.00	
HSP Bonus Payment Amount					
0.00 HSP bonus amount (see instructions)			1.00		100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)	oo i notructi anc)		0. 0000000000	0.000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 11.00 HVBP adjustment factor (see instructions) 12.00 HVBP adjustment amount for HSP bonus payment (se	ee instructions)		0	0.000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see HRR Adjustment for HSP Bonus Payment	ee instructions)		0. 0000000000	0.0000000000 0.00000000000000000000000	101 102
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 11.00 HVBP adjustment factor (see instructions) 12.00 HVBP adjustment amount for HSP bonus payment (see HRR Adjustment for HSP Bonus Payment 13.00 HRR adjustment factor (see instructions) 			0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR Adjustment for HSP Bonus Payment 04.00 HRR adjustment amount for HSP bonus payment (see instructions)	e instructions)		0. 0000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103
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CUL	Financial Systems ORTHOPAEDIC HOSPT. ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0167	Peri od: From 01/01/2017	u of Form CMS-: Worksheet E Part B	
			To 12/31/2017	Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2018 7:4 PPS	0 am
			nospi tai		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			0	1.
00	Medical and other services reimbursed under OPPS (see instruc	tions)		2, 731, 038	
00	OPPS payments			2, 321, 720	
)0)1	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			20, 918	
0	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
0	Line 2 times line 5			0	
0	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COL. 13, 11ne 200		0	
00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonable charges			0	12.
00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	The obj		0	
	Customary charges				
00	Aggregate amount actually collected from patients liable for				15
00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16
00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17
	Total customary charges (see instructions)			0.000000	
00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	
	instructions)	5			
00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20
00	instructions) Lesser of cost or charges (see instructions)			0	21
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		2, 342, 638	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
00 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH soo instructions	N N N N N N N N N N N N N N N N N N N	446, 896	25
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			1, 895, 742	
	instructions)		(.,	
	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	
00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			1, 895, 742	
	Primary payer payments Subtotal (line 30 minus line 31)			633 1, 895, 109	
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI)	CES)			1
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
	Allowable bad debts (see instructions)			39, 629	
00	Adjusted reimbursable bad debts (see instructions)	ruoti ana)		25, 759	
00 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		39, 629 1, 920, 868	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	s)			39
97	Demonstration payment adjustment amount before sequestration			0	
98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	ctions)	0	
99 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 920, 868	
00	Sequestration adjustment (see instructions)			38, 417	
	Demonstration payment adjustment amount after sequestration			0	
00	Interim payments			1, 851, 497	
	Tentative settlement (for contractors use only)			0	
00	Balance due provider/program (see instructions)	noo with CNC Dut 15 0	chapter 1	30, 954	
00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with UMS PUD. 15-2,	chapter I,	0	44
	TO BE COMPLETED BY CONTRACTOR				1
00	Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92
00 00	Time Value of Money (see instructions)			· ·	93

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-0167	Period: From 01/01/2017 To 12/31/2017		pared
		Title		Hospi tal	PPS	
		Inpatient	t Part A	Pa	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, 630, 1	04 0	1, 851, 497 0	
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	
03 04				0	0	
04				0	0	
00	Provider to Program	II				
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		10, 630, 1	04	1, 851, 497	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	
52				0	0	
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		4,6	32 0	30, 954	6. 6.
02 00	Total Medicare program liability (see instructions)		10, 634, 7	-	1, 882, 451	
			10,004,7	Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1	1.00	2.00	

3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 10 Internet 168 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 31.00 Other Adjustment (specify) 31.00	Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-	2552-10
To 12/31/2017 Date/Time Prepared: 5/30/2018 7: 40 am Title XVIII Hospital PPS To BECOMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS 1.00 To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 OUTOTAL hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2 4.00 Total hospital charges from Wkst. S-3, Pt. I, col. 8 line 200 5.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I III ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 0.00 Colspan="2">Colspan="2">Colspan="2">Date/Time Prepared: 5/30/2018 7: 40 am 1.00 Colspan="2">1.00 Colspan="2">1.00 Colspan="2">1.00 <td>CALCUL</td> <td>ATION OF REIMBURSEMENT SETTLEMENT FOR HIT</td> <td>Provider CCN: 15-0167</td> <td></td> <td></td> <td></td>	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0167			
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 3.00 4.00 Total hospital charges from Wkst C, Pt. I, col. 8 sum of lines 1, 8-12 3.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 4.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Initial /interim HIT payment adjustment (see instructions) 10.00 10.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00				To 12/31/2017		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HWO days from S-3, Pt. I, col. 8 sum of lines 1, 8-123.004.00Total hospital charges from Wkst. S-3, Pt. I, col. 8 line 2003.005.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)31.00			Title XVIII	Hospi tal	PPS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HWO days from S-3, Pt. I, col. 8 sum of lines 1, 8-123.004.00Total hospital charges from Wkst. S-3, Pt. I, col. 8 line 2003.005.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)31.00						
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2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00						-
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of Lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 Line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 Line 20 5.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 6.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 9.00 10.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00				e 14		
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00			-12			2.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	3.00					3.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 8.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 8.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
I ine 168 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 10.00 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	6.00	Total hospital charity care charges from Wkst. S-10, col. 3 [ine 20			6.00
8.00 Calculation of the HIT incentive payment (see instructions) 8.00 9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
9.00 Sequestration adjustment amount (see instructions) 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00		line 168				
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 30.00 Initial /interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify) 31.00	8.00	Calculation of the HIT incentive payment (see instructions)				8.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial /interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)	9.00	Sequestration adjustment amount (see instructions)				9.00
30.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)31.00	10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
31.00 Other Adjustment (specify) 31.00		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
31.00 Other Adjustment (specify) 31.00	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
						31.00
			ine 31) (see instruction	is)		32.00

	E SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 01/01/2017	Worksheet G	
na-t Iy)	ype accounting records, complete the General Fund column			0 12/31/2017	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/30/2018 7:4 Plant Fund	ar
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	4, 706, 906	C	0	0	1 1.
00	Temporary investments	0	C	0	0	2
00	Notes receivable	0	C	0	0	
00	Accounts receivable	22, 046, 723	C	0	0	
00	Other receivable	0	0	0	0	
00 00	Allowances for uncollectible notes and accounts receivable	798		0	0	
00 00	Inventory Prepaid expenses	-2, 293, 395		0	0	
00	Other current assets	2, 2, 3, 3, 3		0	0	
. 00	Due from other funds	o o		Ő	0	
00	Total current assets (sum of lines 1-10)	24, 461, 032		0	0	
	FI XED ASSETS			· · · · ·		
. 00	Land	0	C	0	0	12
. 00	Land improvements	0	C	0	0	13
. 00	Accumulated depreciation	0	C	0	0	
. 00	Buildings	9, 446, 043		0	0	
. 00	Accumulated depreciation	-2, 673, 473		0	0	
. 00	Leasehold improvements	6, 304, 260		0	0	
. 00 . 00	Accumulated depreciation Fixed equipment	-2, 272, 701 157, 301		0	0	
. 00	Accumulated depreciation	-85, 873		0	0	1
. 00	Automobiles and trucks	21, 045		0	0	
. 00	Accumulated depreciation	-12, 715		0	0	
. 00	Major movable equipment	21, 811, 621		0	0	
. 00	Accumulated depreciation	-13, 416, 164	c	0	0	24
. 00	Minor equipment depreciable	0	C	0	0	25
. 00	Accumulated depreciation	0	C	0	0	26
. 00	HIT designated Assets	0	C	0	0	
. 00	Accumulated depreciation	0	C	0	0	
. 00	Minor equipment-nondepreciable	0	C	-	0	
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	19, 279, 344	C	0	0	30
. 00	Investments	0	C	ol	0	3.
. 00	Deposits on Leases			0	0	
. 00	Due from owners/officers	o o		Ő	0	
. 00	Other assets	57, 158, 247	C C	0	0	
. 00	Total other assets (sum of lines 31-34)	57, 158, 247	c c	0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	100, 898, 623	C	0	0	36
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	5, 622, 303	C	0	0	
. 00	Sal ari es, wages, and fees payable	0	C	0	0	
. 00	Payroll taxes payable	0		0	0	
	Notes and Loans payable (short term)	631, 666		0	0	1
. 00 . 00	Deferred income Accelerated payments			0	0	41
. 00	Due to other funds			0	0	
. 00	Other current liabilities	1, 467, 809		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	7, 721, 778			0	
	LONG TERM LI ABI LI TI ES	.,.=.,	-	-1	-	1
. 00	Mortgage payable	0	C	0	0	46
. 00	Notes payable	0	C	0	0	4
. 00	Unsecured Loans	0	0	0	0	
. 00	Other long term liabilities	5, 935, 760		0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	5, 935, 760			0	
. 00	Total liabilities (sum of lines 45 and 50)	13, 657, 538	C	0	0	51
00	CAPITAL ACCOUNTS	07 041 005				1
. 00	General fund balance	87, 241, 085	0			52
. 00 . 00	Specific purpose fund Donor created - endowment fund balance - restricted			0		53
. 00	Donor created - endowment fund balance - restricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
-	replacement, and expansion				-	
00	Total fund balances (sum of lines 52 thru 58)	87, 241, 085	0	0	0	59
. 00						

Heal th	Financial Systems 0	RTHOPAEDIC HOSP	T. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0167	Period: From 01/01/2017 To 12/31/2017	Worksheet G-1 Date/Time Prep 5/30/2018 7:40	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions TRANSFERS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	277, 597, 929 73, 917, 283 351, 515, 212 1 351, 515, 213 264, 300, 000 87, 215, 213			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions TRANSFERS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES			Period: From 01/01/2017	Worksheet G-2	
				To 12/31/2017		
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		7 0/0 5	10	7 0/2 512	1 1 0
1.00			7, 862, 5	12	7, 862, 512	1.00
2.00 3.00	SUBPROVI DER – I PF SUBPROVI DER – I RF					3.00
3.00 4.00	SUBPROVIDER - TRF					4.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0		7.00
8.00	NURSI NG FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 862, 5	12	7, 862, 512	
	Intensive Care Type Inpatient Hospital Services		.,, .	· =]	1 .,	1
11.00	INTENSIVE CARE UNIT					1 11. 0
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
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, 862, 5		7, 862, 512	
18.00	Ancillary services		210, 144, 5			18.00
19.00	Outpatient services			0 134, 609, 491	134, 609, 491	19.00
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 93, 180, 076	93, 180, 076	
26.00	HOSPICE			10	10 0/4 540	26.00
27.00	THERAPY REVENUE	to Wkot	13,064,5		10/001/012	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to WKST.	231, 071, 5	55 227, 789, 567	458, 861, 122	28.0
	G-3, line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			87, 533, 045	5	29.00
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.00
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			(36.0
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.0
39.00				0		39.00
40.00				0		40.0
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			(42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		87, 533, 045	5	43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0167	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	arod
			10 12/31/2017	5/30/2018 7:40	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			458, 861, 122	1.00
2.00	Less contractual allowances and discounts on patients' account	its		297, 923, 612	2.00
3.00	Net patient revenues (line 1 minus line 2)			160, 937, 510	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		87, 533, 045	4.00
5.00	Net income from service to patients (line 3 minus line 4)			73, 404, 465	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			1, 757	6.00
7.00	Income from investments			47,033	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00				0	12.00
13.00				0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other t	han patients		9, 136	
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21.00
	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	OTHER OPERATING REVENUES			451,090	
	Total other income (sum of lines 6-24)			509, 016	
	Total (line 5 plus line 25)			73, 913, 481	26.00
	GAIN OF SALE OF ASSETS			-3, 802	
	Total other expenses (sum of line 27 and subscripts)			-3,802	
29.00	Net income (or loss) for the period (line 26 minus line 28)		I	73, 917, 283	29.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0167	Period: From 01/01/2017	Worksheet L Parts I-III	
			To 12/31/2017	Date/Time Pre 5/30/2018 7:40	
		Title XVIII	Hospi tal	PPS	o am
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier			875, 002	1.
01	Model 4 BPCI Capital DRG other than outlier			0	1.
00	Capital DRG outlier payments			0	2.
01	Model 4 BPCI Capital DRG outlier payments			0	2.
00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	14.79	3.
00	Number of interns & residents (see instructions)			0.00	4.
00	Indirect medical education percentage (see instructions)			0.00	5.
00	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines i and i. Ui	, corumns r and	0	6.
00	 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 			0.00	7.
00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8
00	Sum of lines 7 and 8	,		0.00	9
. 00	Allowable disproportionate share percentage (see instruction	ns)		0.00	10
. 00	Disproportionate share adjustment (see instructions)			0	11
. 00	Total prospective capital payments (see instructions)			875, 002	12
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	1.
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	4
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	
00 00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2
00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0.00	3
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5
00	Percentage adjustment for extraordinary circumstances (see i	instructions)		0.00	
00	Adjustment to capital minimum payment level for extraordinar		(line 6)	0	7
00	Capital minimum payment level (line 5 plus line 7)		-	0	8
00	Current year capital payments (from Part I, line 12, as appl			0	
. 00	Current year comparison of capital minimum payment level to	1 1 5 1		0	10
. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)		5	0	11.
	Net comparison of capital minimum payment level to capital p		,	0	
				0	13
$- \alpha \alpha$	Carryover of accumulated capital minimum payment level over	capital payment for the f	ollowing period	0	14
ŧ. UU					1
	(if line 12 is negative, enter the amount on this line)	nstructions)		0	15
5. 00	Current year allowable operating and capital payment (see in Current year operating and capital payment (see in Current year operating and capital costs (see instructions)	nstructions)		0	