PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

use only

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ORTHOPAEDIC HOSPT. AT PARKVIEW (15-0167) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

> JEANNE WICKENS (Si gned) Officer or Administrator of Provider(s)

> > SVP/CF0

Title

(Dated when report is electronically signed.)

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	12, 730	33, 771	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - 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	12, 730	33, 771	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. 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.

reporting period different from the method daed in the piror cost							
reporting period? In column 2, enter "	$^{\prime exttt{"}}$ for yes or "N" for no	,					
	In-State	In-State	Out-of	Out-of	Medi cai	id Other	
	Medi cai d	Medi cai d	State	State	HMO day	ys Medicaid	
	paid days	eligible	Medi cai d	Medi cai d	1	days	
	'	unpai d	paid days	eligible			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6.00	1
24.00 If this provider is an IPPS hospital, er	nter the C	C	0	0		0 0	24. (
in-state Medicaid paid days in column 1,	in-state						
Medicaid eligible unpaid days in column	2,						
out-of-state Medicaid paid days in colur	ın 3,						
out-of-state Medicaid eligible unpaid da	ys in column						
4, Medicaid HMO paid and eligible but ur	paid days in						
column 5, and other Medicaid days in col	ilmp 6						

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMP		OLC HOSPT. A	Provider CC	:N: 15-0167	Peri od:	III LI		Form CMS- sheet S-2	
OST THE NEW TOOL THE TENET ONLY SOME	EEX TEENTH ON TON B				From 01/0 To 12/3	1/2018	Part Date 5/28	: I :/Time Pre :/2019 3:4	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d	lays	Other Medicaid days	
5.00 If this provider is an IRF, ente	r the in-state	1.00	2.00	3.00	4. 00	5.0	0	6. 00	25. (
Medicaid paid days in column 1, Medicaid eligible unpaid days in out-of-state Medicaid days in co Medicaid eligible unpaid days ir HMO paid and eligible but unpaid	the in-state column 2, lumn 3, out-of-state column 4, Medicaid	U	0	U					
					1. (Date	of Geogr	
6.00 Enter your standard geographic o	lassification (not w	age) status	at the beg	ginning of t			1	2.00	26.
cost reporting period. Enter "1" 7.00 Enter your standard geographic creporting period. Enter in columenter the effective date of the	lassification (not w n 1, "1" for urban o geographic reclassif	age) status r "2" for r ication in	ural. If ap column 2.	ppl i cabl e,			1		27.
5.00 If this is a sole community hosp		e number of	peri ods SC	CH status in		(0		35.
effect in the cost reporting per	i ou.				Begi nı	ni ng:	E	ndi ng:	
00 5				0/ 6	1. (00		2.00	
.00 Enter applicable beginning and e of periods in excess of one and	3		cript line	36 TOT NUMB	er				36.
.00 If this is a Medicare dependent	hospital (MDH), ente		r of period	ds MDH statu	s	(0		37.
<pre>is in effect in the cost reporti O1 Is this hospital a former MDH th accordance with FY 2016 OPPS fir instructions)</pre>	at is eligible for t								37
.00 If line 37 is 1, enter the beging reater than 1, subscript this lenter subsequent dates.									38
					Y/			Y/N	
.00 Does this facility qualify for t	ha innationt bassita	l paymont a	diustmont f	For Low volu	1.0 me Y			2. 00 N	39.
hospitals in accordance with 42 1 "Y" for yes or "N" for no. Doe accordance with 42 CFR 412.101(b or "N" for no. (see instructions	CFR §412.101(b)(2)(i) s the facility meet (2)(i), (ii), or (i), (ii), or the mileage	(iii)? Ent	er in colum nts in	n			IV	39.
.00 Is this hospital subject to the "N" for no in column 1, for disc no in column 2, for discharges o	harges prior to Octo	ber 1. Ente	r "Y" for y					N	40.
						1.0			+
Prospective Payment System (PPS)									
OD Does this facility qualify and r with 42 CFR Section §412.320? (s OD Is this facility eligible for ac	ee instructions)		•			N N			45
pursuant to 42 CFR §412.348(f)? Pt. III.	If yes, complete Wks	t. L, Pt. I	II and Wkst	. L-1, Pt.	I through				
.00 Is this a new hospital under 42						N N			47
Teaching Hospitals Teaching Hospitals Teaching Hospital involved in t	1 1 2					N			56
or "N" for no. 100 If line 56 is yes, is this the f GME programs trained at this fac	ility? Enter "Y" fo	r yes or "N	" for no ir	n column 1.	If column 1				57
is "Y" did residents start trair	2. If column 2 is "	Y", complet I, if appli	e Worksheet cable.	E-4. If co	lumn 2 is				
for yes or "N" for no in column "N", complete Wkst. D, Parts III		hursamant f		ans' service	s as	N			58
"N", complete Wkst. D, Parts III 00 If line 56 is yes, did this faci defined in CMS Pub. 15-1, chapte	lity elect cost reim er 21, §2148? If yes,	complete W		D					1 50
"N", complete Wkst. D, Parts III .00 If line 56 is yes, did this faci defined in CMS Pub. 15-1, chapte	lity elect cost reim er 21, §2148? If yes,	complete W		Pt. I. NAHE 413.8	35 Worksh	eet A			39
"N", complete Wkst. D, Parts III 3.00 If line 56 is yes, did this faci	lity elect cost reim er 21, §2148? If yes,	complete W			35 Worksh Line	eet A	Pass Qual		
"N", complete Wkst. D, Parts III 1.00 If line 56 is yes, did this faci defined in CMS Pub. 15-1, chapte	lity elect cost reim er 21, §2148? If yes,	complete W		NAHE 413.8		eet A e #	Pass Qual Cri te	i fi cati on	

Heal th	Financial Systems ORTHOPAED	IC HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
		Y/N	IME	Direct GME	I ME	5/28/2019 3:4 Direct GME	9 piii
		1.00	2. 00	3. 00	4.00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N			0.00	0.00	61. 00
	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 ACA). (see instructions)						61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary						61. 04
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2. 00	3. 00	4.00	
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 10
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
						1.00	
(2, 22	ACA Provisions Affecting the Health Resources and Ser						(2, 22
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	tions)					62. 00 62. 01
63.00	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti	ngs		period? Enter	N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple			67. (see instri	uctions)		
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1 00	2 00	2 00	

		Site			
		1. 00	2.00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0167 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 3:49 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems ORTHOPAEDIC HOSPT. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	wof Form CMS Worksheet S- Part I Date/Time Pr 5/28/2019 3:	2 epared:
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded				N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	under section		N	87. 00
11880(d)(1)(b)(VI)? Eliter 1 Tol yes of N Tol Ho.			V	XI X	
			1.00	2.00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? Er	nter "Y" for	N	Y	90. 00
91.00 Is this hospital reimbursed for title V and/or XIX through the			N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the applic 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	l certificati			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable 93.00 Does this facility operate an ICF/IID facility for purposes or		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an	nd "N" for no	in the	N	N	94. 00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appli			0. 00	0.00	95. 00
96. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for no	o in the	N	N	96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appli 98.00 Does title V or XIX follow Medicare (title XVIII) for the into stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	erns and resi	dents post	0. 00 Y	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the repr C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes 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 routpatient services cost? Enter "Y" for yes or "N" for no in oin column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add bacl Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.				Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost re Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. Rural Providers			Y	Y	98. 06
105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-in for outpatient services? (see instructions)	nclusive meth	nod of paymen	1		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost of training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	1. (see instr	ructions) If	t		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CL CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sched	dul e? See 42	N		108. 00
	Physi cal	Occupationa		Respi ratory	
	1. 00	2. 00	3. 00	4. 00	
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.	N				109. 00

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

1.00

N

110. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-0167			Worksheet S-	-2
		To	01/01/201 12/31/201		
			1. 00	2.00	\dashv
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction for the construction for the construction of the FCHIP demonstration promates the construction of the FCHIP demonstrates and the construction of the FCHIP demonstrates and the construction of the constr	ost reporting period? En Dlumn 1 is Y, enter the cticipating in column 2.		N N	2.00	111.00
Ni seel Lancous Cost Deporting Information			1.	00 2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub.15-1, chapter 22, §2208.1.	If column 2 is "E", en nt for long term care (i rs) based on the definit	ter in c ncludes	olumn MS		115. 0
16.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurate. no.	rance? Enter "Y" for yes			,	116. 00
I18.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the pol	icy is	1		118. 0
	Premi u	ns	Losses	Insurance	
	1.00		2. 00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	25	5, 147		0 1, 86	52 118. 0
			1. 00	2.00	
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 IDO NOT USE THIS LINE		S	N		118. 0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y" for yes ualifies for the Outpati	or	N	N	120. 0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices charged	to	Υ		121. 0
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N		122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N" for no. I	f	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, er		ate			126. 0
in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certification da	te			127. 0
28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	ter the certification da	te			128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		e in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col					130. 0
31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	umn 2.				131. 0
32.00 f this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				132. 0
133.00 If this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2 134.00 If this is an organ procurement organization (OPO), enter th	2.				133. 00
and termination date, if applicable, in column 2. All Providers	ie di di ridinder i i i coi dilli	•			- 134.0
140.00 Are there any related organization or home office costs as complete the chapter 10? Enter "Y" for yes or "N" for no in column 1. If			Υ	15H032	140. 0

						1.00	1
44.00 Are provider based physicians' co	sts included in Workshee	et A?				N	144. 0
				-	1. 00	2. 00	+
4F 00 6t- 6	-: W A	74 ++-	£		1.00	2.00	145 0
45.00 If costs for renal services are c							145. 0
inpatient services only? Enter "Y				;			
no, does the dialysis facility in		on for this cost	reporting				
period? Enter "Y" for yes or "N"	for no in column 2.						
46.00 Has the cost allocation methodolo	gy changed from the prev	iously filed cost	report?		N		146. 0
Enter "Y" for yes or "N" for no i				lf			
yes, enter the approval date (mm/		. To 2, chapter in	0, 31020)				
lyes, enter the approvar date (iiiii)	du/yyyy) 111 COI dilli1 2.						
						1 00	+
						1.00	
47.00 Was there a change in the statist	ical basis? Enter "Y" fo	or yes or "N" for i	no.			N	147. 0
48.00 Was there a change in the order o	f allocation? Enter "Y"	for yes or "N" for	r no.			N	148. 0
49.00 Was there a change to the simplif	ied cost finding method?	PEnter "Y" for yes	s or "N" f	or no.		N	149. 0
		Part A	Part E		Title V	Title XIX	
		1.00	2.00		3.00	4. 00	1
Does this facility contain a prov	iden that qualified for			ooti on			
or charges? Enter "Y" for yes or	N for no for each comp			s. (See			4
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156. 0
57.00 Subprovi der – IRF		N	N		N	N	157. C
58. OO SUBPROVI DER				1			158. C
59. 00 SNF		N	N		N	N	159.0
50. OO HOME HEALTH AGENCY		N I	N	1	N	N	160. 0
		IN IN		1			
51. 00 CMHC			N		N	N	161. C
						1.00	
Mul ti campus							
65.00 s this hospital part of a Multic	amous hospital that has	one or more campu	ses in dif	ferent	CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.						**	
Enter 1 for yes of N for no.	Name	County	State	Zip Cod	le CBSA	FTE/Campus	
	0						+
	Ü	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 If line 165 is yes, for each						0.00	166. 0
campus enter the name in column							1
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
cordinar 5 (See Fristractions)							
						1 00	+
						1. 00	-
Health Information Technology (HI				ment Act	Ţ		4
67.00 Is this provider a meaningful use						Υ	167. 0
(O OOLE +L' ' CAU (I : 1	05 is "Y") and is a mean	ningful user (line	167 is "Y	"), ent	er the		d168. 0
88.00 IT this provider is a CAH (line i				•			
reasonable cost incurred for the	HIT assets (see instruct	.1 0115)			ırdshi n		168. 0
reasonable cost incurred for the			qualify f	or a ha			1.00.0
reasonable cost incurred for the 68.01 If this provider is a CAH and is	not a meaningful user, d	loes this provider					1
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, d ? Enter "Y" for yes or "	loes this provider N" for no. (see i	nstructi or	ıs)		0.0	d1/0 0
reasonable cost incurred for the 158.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a	loes this provider N" for no. (see i	nstructi or	ıs)		9. 9	9169. 0
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a	loes this provider N" for no. (see i	nstructi or	s "N"),	enter the		9169. 0
reasonable cost incurred for the 18.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a	loes this provider N" for no. (see i	nstructi or	s "N"),	enter the Beginning	Endi ng	9169. 0
reasonable cost incurred for the 88.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 99.00 If this provider is a meaningful	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a	loes this provider N" for no. (see i	nstructi or	s "N"),	enter the		9169. C
reasonable cost incurred for the 18.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	loes this provider N" for no. (see in and is not a CAH (l	nstruction line 105 i	ns) s "N"),	enter the Beginning	Endi ng	
reasonable cost incurred for the lf this provider is a CAH and is exception under §413.70(a)(6)(ii) 99.00 If this provider is a meaningful transition factor. (see instruction 20.00 Enter in columns 1 and 2 the EHR	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	loes this provider N" for no. (see in and is not a CAH (l	nstruction line 105 i	ns) s "N"),	enter the Beginning 1.00	Endi ng 2. 00	
reasonable cost incurred for the 18.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	loes this provider N" for no. (see in and is not a CAH (l	nstruction line 105 i	ns) s "N"),	enter the Beginning 1.00	Endi ng 2. 00	
reasonable cost incurred for the If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	not a meaningful user, d ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	loes this provider N" for no. (see in and is not a CAH (l	nstruction line 105 i	ns) s "N"),	enter the Beginning 1.00 0/01/2016	Endi ng 2. 00 09/30/2017	
reasonable cost incurred for the If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	not a meaningful user, of Penter "Y" for yes or "user (line 167 is "Y") aons)	loes this provider N" for no. (see in and is not a CAH (l	nstruction line 105 i porting	ns) s "N"),	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	170. 0
reasonable cost incurred for the lf this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this pro	not a meaningful user, of Pitter "Y" for yes or "user (line 167 is "Y") aons) beginning date and endir	loes this provider N" for no. (see indis not a CAH (long date for the replaced individuals enrol	nstruction line 105 i porting	ns) s "N"), 	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	9169. 0 170. 0
reasonable cost incurred for the lf this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans	not a meaningful user, of Pitter "Y" for yes or "user (line 167 is "Y") a ons) beginning date and ending the pitter have any days for reported on Wkst. S-3, F	loes this provider N" for no. (see ind is not a CAH (long date for the replication of the control of the contro	nstruction line 105 i porting led in . 6? Enter	ns) s "N"), [1	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	170. 0
reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this pro	not a meaningful user, of Pitter "Y" for yes or "user (line 167 is "Y") a ons) beginning date and ending the pitter have any days for reported on Wkst. S-3, F	loes this provider N" for no. (see ind is not a CAH (long date for the replication of the control of the contro	nstruction line 105 i porting led in . 6? Enter	ns) s "N"), [1	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	170. 0
reasonable cost incurred for the If this provider is a CAH and is exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instruction of the expectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in col	not a meaningful user, of Pinter "Y" for yes or "user (line 167 is "Y") a ons) beginning date and endire ovider have any days for reported on Wkst. S-3, Fumn 1. If column 1 is ye	loes this provider N" for no. (see ind is not a CAH (long date for the replication of the control of the contro	nstruction line 105 i porting led in . 6? Enter	ns) s "N"), [1	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	170. 0
reasonable cost incurred for the If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans	not a meaningful user, of Pinter "Y" for yes or "user (line 167 is "Y") a ons) beginning date and endire ovider have any days for reported on Wkst. S-3, Fumn 1. If column 1 is ye	loes this provider N" for no. (see ind is not a CAH (long date for the replication of the control of the contro	nstruction line 105 i porting led in . 6? Enter	ns) s "N"), [1	enter the Beginning 1.00 0/01/2016	Endi ng 2.00 09/30/2017	170. 0

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	5/28/2019 3:4	epared
				Y/N	Date	
	Conoral Instruction, Enter V for all VES recogness. Enter N	for all NO re	cnoncoc Ent	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	TOT ALL NO FE	esponses. Ente	er arr dates in t	ne	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see)		
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2. 00	3. 00	2.0
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	nn 3, "V" for	N N			3.0
	contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board				0. 0
			Y/N	Type	Date	
			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" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, uilable in	Y	A	03/27/2018	4. 0
00	those on the filed financial statements? If yes, submit rec] 5. \
	,		1	Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	s N		6. (
00 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N		11.
					Y/N 1.00	
	Bad Debts					
	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. 13.
1. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	fyes, see ins	structi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti		yes, see ins [.] -t A	tructions.	N t B	15.
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
. 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 date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	05/01/2018	Y	04/28/2017	17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

Heal th	Financial Systems ORTHOPAEDIC HOSP	PT. AT PARKVIEW		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-: Part II Date/Time Pro 5/28/2019 3:-	epared:
			i pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
04.00		1.00	2. 00	3. 00	4. 00	04.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entere	d into during	this cost re	porting period?		24. 00
	If yes, see instructions					
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost reporti	na period? L	f ves see		26. 00
20.00	instructions.	ic cost reporti	ng perrou. I	, yes, see		20.00
27. 00	Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28. 00
	period? If yes, see instructions.		o .			
29. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ves	see	N	30.00
00.00	instructions.		4021 you	, 555		00.00
31. 00	Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes	, see	N	31. 00
	instructions. Purchased Services					-
32. 00	Have changes or new agreements occurred in patient care ser	vi ces furni she	ed through co	ntractual	N	32. 00
	arrangements with suppliers of services? If yes, see instru	icti ons.				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	olied pertainir	ng to competi	tive bidding? If		33. 00
	no, see instructions. Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physi ci ans?	N	34. 00
	If yes, see instructions.					1
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	provi der-based		35. 00
	physicians during the cost reporting period: 11 yes, see in	311 4011 0113.		Y/N	Date	
				1. 00	2. 00	
27, 00	Home Office Costs			V		2/ 00
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y		36. 00 37. 00
200	If yes, see instructions.	ou by 1110	5111601			37.00
38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, N		39. 00
37.00	see instructions.	a charn compor	ients: II yes	, IN		37.00
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	instructions.					
		1	00	2.	00	
	Cost Report Preparer Contact Information	1.		Σ.		
41. 00	Enter the first name, last name and the title/position	ERI C		NI CKESON		41. 00
	held by the cost report preparer in columns 1, 2, and 3,					
42. 00	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	H SYSTEM. IN	c.		42. 00
	preparer.					
43. 00		(260) 373-8406)	ERI C. NI CKESON@I	PARKVI EW. COM	43. 00
	report preparer in columns 1 and 2, respectively.			I		II

Health Financial Systems ORTHOPAEDIC HOS			SPT. AT PARKVI EW			In Lieu of Form CMS-2552-				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi de	er CCN: 15-0167	Peri Fron To	i od: m 01/01/2018 12/31/2018		Prep	pared:		
				3. 00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the title/pos		DI RECTOR, I	REIMBURSEMENT					41.00	
	held by the cost report preparer in columns 1, 2	, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the cost repo	rt							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	'.								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

outpatient days (see instructions)

33.01 LTCH site neutral days and discharges

LTCH non-covered days

33.00

From 01/01/2018 12/31/2018

Part I

33.00

33.01

Date/Time Prepared: 5/28/2019 3:49 pm I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH Hours Title V Line Number Avai I abl e 5.00 1.00 2.00 3.00 4.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 37 13, 505 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 37 13, 505 0.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 37 13, 505 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 115.00 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 30.00 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26, 25 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 26.25 27.00 Total (sum of lines 14-26) 37 27.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 29.00 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.01 32.01

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

Provider CCN: 15-0167

				'	0 12/31/2010	5/28/2019 3: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	-
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	30p01161112			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 754	62	5, 407			1.00
2.00	HMO and other (see instructions)	1, 548	56				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	o	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	l ol	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF]	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 754	62	5, 407			7. 00
	beds) (see instructions)	, -	-				
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	1, 754	62	5, 407	0.00	175. 01	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l e	26. 25
27. 00	Total (sum of lines 14-26)			, , ,	0.00	175. 01	
28. 00	Observation Bed Days		9	686			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			101			30.00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	ı Y		I	I	I	33. 01

Provider CCN: 15-0167

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

					12/31/2010	5/28/2019 3: 4	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00 2. 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)		0	892 797	30	2, 962	2.00
3.00	HMO IPF Subprovider			171	30		3.00
4. 00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				U		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	892	4	2, 962	
15. 00	CAH visits	0.00	Ü	072	7	2, 702	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0167

					Ţ	o 12/31/2018	Date/Time Prep 5/28/2019 3:49	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	,	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	22, 802, 686	10, 786, 642	33, 589, 328	1, 080, 279. 00	31. 09	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4. 00
	Admi ni strati ve		-	0				
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	1	
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	О	О	0.00	0.00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved		_	_	_			
8. 00	programs) Home office and/or related		0	7, 071, 214	7, 071, 214	214, 713. 00	32. 93	8. 00
9. 00	organization personnel SNF	44. 00	0	o	o	0. 00	0. 00	9. 00
10.00	Excluded area salaries (see		10, 100, 454	1, 806, 454	11, 906, 908		1	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		0	0	0	0. 00	0.00	13. 00
	A - Administrative			0				14. 00
14. 00	Home office and/or related organization salaries and		U	0	0	0. 00	0.00	14.00
14. 01	wage-related costs Home office salaries		0	7, 071, 214	7, 071, 214	214, 713. 00	32. 93	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
	- Administrative		O					
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		6, 125, 656	0	6, 125, 656			17. 00
	instructions)			_	2, 122, 222			
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		3, 363, 906	0	3, 363, 906 0			19. 00 20. 00
	A		0					
21. 00	Non-physician anesthetist Part B		U	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		3, 846, 804	0	3, 846, 804			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		n	n	n			25. 52
20.02	- Administrative -		Ŭ					25. 52
25. 53	II I		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
24.00	OVERHEAD COSTS - DIRECT SALARIE		2 550 247	2 550 047		0.00	0.00	24 00
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00					1	26. 00 27. 00
		,						

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0167

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/201

							5/28/2019 3: 4	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00		152, 152	152, 152			30. 00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	266, 853	112, 949	379, 802	22, 692. 00	16. 74	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	0	239, 939	239, 939	7, 286. 00		34.00
35.00	Di etary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00		0	0	0.00		36.00
37.00	Maintenance of Personnel	12. 00		0	0	0. 00	0.00	
38. 00	Nursing Administration	13. 00	0	0	0	0. 00	0.00	38. 00
39. 00	Central Services and Supply	14. 00	0	29, 727	29, 727	903.00	32. 92	39. 00
40.00	Pharmacy	15. 00	0	12, 393	12, 393	376.00	32. 96	40.00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	227, 740	42, 356	270, 096	7, 377. 00	36. 61	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

33. 31

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0167 Worksheet S-3 Peri od: From 01/01/2018 To 12/31/2018 Part III Date/Time Prepared: 5/28/2019 3:49 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 22, 802, 686 3, 715, 428 26, 518, 114 865, 566. 00 1.00 30.64 instructions) 2.00 10, 100, 454 11, 906, 908 425, 914. 00 27. 96 2.00 Excluded area salaries (see 1, 806, 454 instructions) 3.00 Subtotal salaries (line 1 12, 702, 232 1, 908, 974 14, 611, 206 439, 652. 00 33. 23 3.00 minus line 2) 4.00 Subtotal other wages & related 0 7, 071, 214 7, 071, 214 214, 713. 00 32. 93 4.00 costs (see inst.) Subtotal wage-related costs 5.00 9, 972, 460 Ω 9, 972, 460 0.00 68. 25 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 22, 674, 692 8, 980, 188 31, 654, 880 654, 365. 00 48 37

4, 013, 694

5, 145, 866

9, 159, 560

274, 954. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0167		Worksheet S-3
		From 01/01/2018	

		To 12/31/2018	Date/Time Pre 5/28/2019 3:4	
			Amount	•
			Reported	
			1. 00	
	PART IV - WAGE RELATED COSTS			
	Part A - Core List			
	RETI REMENT COST			
1.00	401K Empl oyer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		436, 267	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		2, 141, 027	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		3, 917	6.00
7.00	Employee Managed Care Program Administration Fees		61, 376	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	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)		4, 791, 797	8. 02
8.03	Health Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		0	9. 00
10.00			0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		48, 881	11. 00
12.00			0	12.00
13.00			110, 770	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14. 00
15.00	'Workers' Compensation Insurance		26, 709	15. 00
16.00	· ·	ed by FASB 106.	0	16. 00
	Non cumulative portion)	,		
	TAXES			
17.00	FICA-Employers Portion Only		1, 695, 177	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
	OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 thro	ugh 4 above. (see	108, 960	21. 00
	instructions))			
22.00	Day Care Cost and Allowances		0	22. 00
23.00			64, 681	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9, 489, 562	24. 00
	Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prepared: 5/28/2019 3:49 pm
Cost Center Description		Contract Labor	Benefit Cost

			5/28/2019 3: 49	9 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	9, 489, 562	1.00
2.00	Hospi tal	0	9, 489, 562	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (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	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -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	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	Other	0	0	18. 00

OSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN: 15-		Peri od:	Worksheet S-10	0
				From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
				12/31/2010	5/28/2019 3: 4	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202	2 column	8)	0. 160438	1. (
00	Medicaid (see instructions for each line) Net revenue from Medicaid				474, 670	2. (
00	Did you receive DSH or supplemental payments from Medicaid?				474, 670 Y	3.
00						4.
00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicaid			0	5.
00	Medi cai d charges				11, 124, 524	
00	Medicaid cost (line 1 times line 6)			2 5 : 6	1, 784, 796	1
00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine / minus sum	n or line	es 2 and 5; IT	1, 310, 126	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
00	Net revenue from stand-alone CHIP	,			0	9.1
0. 00	Stand-alone CHIP charges				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)				0	1
2. 00	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	ine 11 minus li	ine 9; i	r < zero then	0	12.
	Other state or local government indigent care program (see instru	uctions for eac	ch line)			1
8. 00	Net revenue from state or local indigent care program (Not inclu)	5, 361, 870	13.
. 00	Charges for patients covered under state or local indigent care	program (Not ir	ncl uded i	in lines 6 or	27, 600, 128	14.
	10)					
6. 00 6. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indi	aont cara progr	rom (lin	a 1E minus lina	4, 428, 109 0	1
). UU	13; if < zero then enter zero)	gent care progr	I alli (IIII	e io illitius title	U	10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/loca	al indige	ent care program	ıs (see	
7 00	instructions for each line)					4.7
7. 00 3. 00	Private grants, donations, or endowment income restricted to fun Government grants, appropriations or transfers for support of ho				0	ı
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	1, 310, 126	
	8, 12 and 16)	Uni	nsured	Insured	Total (col. 1	
			tients	patients	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
0. 00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	470, 58	1 808, 547	1, 279, 128	20.
. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	75, 49	9 808, 547	884, 046	21.
	instructions)	15 (555	, 0, 1,	1	33 1, 3 13	
2. 00	Payments received from patients for amounts previously written o	ff as	7, 00	0 4, 349	11, 349	22.
	charity care		(0.40)	004 100	072 (07	22
3. 00	Cost of charity care (line 21 minus line 22)		68, 49	9 804, 198	872, 697	23.
					1. 00	
1. 00	Does the amount on line 20 column 2, include charges for patient		length (of stay limit	N	24.
. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		program'	s length of	0	25.
. 00	stay limit Total bad debt expense for the entire hospital complex (see inst	ructions)			1, 161, 488	26.
7.00	Medicare reimbursable bad debts for the entire hospital complex	,	ons)		1, 101, 400 47, 447	1
. 01	Medicare allowable bad debts for the entire hospital complex (se	,			72, 996	1
	Non-Medicare bad debt expense (see instructions)	·			1, 088, 492	28.
						1 00
8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see instru	uctions)		200, 184	1
3. 00 9. 00 0. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus lin	•	uctions)		200, 184 1, 072, 881 2, 383, 007	30.

		RTHOPAEDIC HOSPT			In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider Co		eriod: rom 01/01/2018	Worksheet A	
				Т.	o 12/31/2018	5/28/2019 3: 4	pared: 9 pm
	Cost Center Description	Sal ari es	0ther		Reclassifications (See A-6)	Reclassified Trial Balance	
				+ col . 2)	ons (see A-6)	(col. 3 +-	
						col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		0.070.070	0.070.070	1 000 (10	4 050 007	
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 273, 979			1, 250, 337	1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		1, 023, 642	1, 023, 642	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 559, 317	5, 241, 023	1	-2, 559, 317	5, 241, 023	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	959, 784	15, 008, 255			16, 761, 278	5. 00
7.00	00700 OPERATION OF PLANT	0	897, 588			897, 588	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	266, 853	336, 476			651, 954	9. 00
10.00	01000 DI ETARY	0	239, 939	239, 939		239, 939	10. 00
11.00	01100 CAFETERI A	0	0	0	0	0	11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0 29, 727		0	0 29, 727	13. 00 14. 00
15. 00	01500 PHARMACY	0	12, 393			12, 393	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	12, 070	12, 070	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	227, 740	1, 475	229, 215	42, 356	271, 571	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 287, 805	488, 947	2, 776, 752	375, 691	3, 152, 443	30. 00
30.00	ANCI LLARY SERVICE COST CENTERS	2, 201, 000	400, 947	2, 770, 732	373, 091	3, 132, 443	30.00
50. 00	05000 OPERATING ROOM	4, 922, 102	31, 075, 040	35, 997, 142	-25, 624, 546	10, 372, 596	50.00
53.00	05300 ANESTHESI OLOGY	225, 942	1, 368			944, 841	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	84, 765	84, 765	-943	83, 822	54.00
58. 00	05800 MRI	411, 658	234, 432	646, 090	70, 574	716, 664	58. 00
60.00	06000 LABORATORY	0	450, 477			450, 477	60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0		0	0 000	62. 30
65. 00 66. 00	06600 PHYSI CAL THERAPY	777, 905	82, 988 16, 600			82, 988 948, 963	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY	777, 403	483			483	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0			3, 653, 512	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0			22, 327, 400	
73.00	07300 DRUGS CHARGED TO PATIENTS	63, 126	2, 039, 399	2, 102, 525	13, 525	2, 116, 050	
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	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	0		0	0	00.00
90. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	U	Ü	0	U	0	90. 00 92. 00
7 ∠. UU	SPECIAL PURPOSE COST CENTERS						72.00
115. 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 246, 171	6, 852, 542	10, 098, 713	0	10, 098, 713	115, 00
118.00		15, 948, 403	65, 367, 896			81, 328, 404	
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	6, 854, 283	7, 486, 728			14, 328, 906	
200.00	TOTAL (SUM OF LINES 118 through 199)	22, 802, 686	72, 854, 624	95, 657, 310	0	95, 657, 310	200. 00

Heal th FinancialSystemsORTHOPAEDICRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0167

| Period: | Worksheet A | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/28/2019 3: 49 pm

				5/28/2019 3:4	49 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8) F	or Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	1, 250, 337		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	O	1, 023, 642		2. 00
3.00	00300 OTHER CAP REL COSTS	ol	o		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-334, 205	4, 906, 818		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 495, 633	21, 256, 911		5. 00
7. 00	00700 OPERATION OF PLANT	0	897, 588		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		077,000		8. 00
9. 00	00900 HOUSEKEEPI NG		651, 954		9. 00
10. 00	01000 DI ETARY		239, 939		10.00
11. 00	01100 CAFETERI A		239, 939		11.00
	I I	_	0		
12.00		0	9		12.00
13.00	I I	0	0		13.00
14.00		0	29, 727		14.00
15. 00		0	12, 393		15. 00
16. 00		0	0		16. 00
17. 00	1	0	271, 571		17. 00
19. 00	1	0	0		19. 00
20. 00		0	0		20. 00
21. 00	1 1	0	0		21. 00
22. 00		0	0		22. 00
23. 00	2 2 2 7	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00		3, 329	3, 155, 772		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00		-1, 940	10, 370, 656		50.00
53.00		0	944, 841		53. 00
54.00		0	83, 822		54. 00
58. 00		0	716, 664		58. 00
60.00		0	450, 477		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	82, 988		65. 00
66.00	06600 PHYSI CAL THERAPY	0	948, 963		66. 00
69.00	06900 ELECTROCARDI OLOGY	0	483		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 653, 512		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	22, 327, 400		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-674	2, 115, 376		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	ol	o		76. 97
76. 98	1	o	o		76. 98
76, 99		o	o		76. 99
	OUTPATIENT SERVICE COST CENTERS		-1		
90.00		0	0		90.00
92. 00			٦		92. 00
50	SPECIAL PURPOSE COST CENTERS				1
115. 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	95, 825	10, 194, 538		115. 00
118. 00		4, 257, 968	85, 586, 372		118. 00
	NONREI MBURSABLE COST CENTERS	1,20.,700	30,000,072		1
194 0	07951 PHYS THERAPY PERFORMANCE CENTER	1, 665, 410	15, 994, 316		194. 00
200.00	1 1	5, 923, 378	101, 580, 688		200.00
_30.0	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	2, 720, 070	,		1

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0167

					10	J 12/31/201	5/28/2019 3: 49 pm
		Increases			<u>'</u>		
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - BUILDING DEPRECIATON						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 023, 642			1.00
	0		0	1, 023, 642			
	B - MED AND IV SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	25, 980, 912			1.00
	PATI ENT						
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4. 00
				25, 980, 912			
	C - TELEPHONE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 670			1.00
2.00		0.00	o	0			2. 00
2.00			-	13, 670			2.00
	D - PTO PAID		<u> </u>	13, 070			
1.00	ADMINISTRATIVE & GENERAL	5.00	17, 173	0			1.00
2.00	HOUSEKEEPI NG	9. 00	3, 550	0			2.00
		•		0			1
3.00	SOCI AL SERVI CE	17. 00	3, 092				3.00
4.00	ADULTS & PEDIATRICS	30.00	32, 445	0			4.00
5.00	OPERATING ROOM	50.00	69, 572	0			5. 00
6.00	ANESTHESI OLOGY	53.00	3, 561	0			6. 00
7.00	MRI	58. 00	5, 447	0			7. 00
8.00	PHYSI CAL THERAPY	66.00	11, 276	0			8. 00
9.00	DRUGS CHARGED TO PATIENTS			0			9. 00
	0		147, 103	0			
	E - PTO EARNED						
1.00	ADMINISTRATIVE & GENERAL	5.00	218, 065	0			1.00
2.00	HOUSEKEEPI NG	9. 00	45, 075	0			2. 00
3.00	SOCI AL SERVI CE	17. 00	39, 264	0			3.00
4.00	ADULTS & PEDIATRICS	30.00	411, 977	0			4.00
5.00	OPERATING ROOM	50.00	883, 404	0			5. 00
6.00	ANESTHESI OLOGY	53.00	45, 211	0			6. 00
7.00	MRI	58. 00	69, 167	0			7. 00
8. 00	PHYSI CAL THERAPY	66. 00	143, 182	O			8.00
9. 00	DRUGS CHARGED TO PATIENTS	73. 00	12, 538				9. 00
7. 00	0		1, 867, 883	0			7. 00
	F - HOME OFFICE		1,007,000	<u> </u>			
1.00	ADMI NI STRATI VE & GENERAL	5.00	5, 264, 761	0			1.00
2.00	AMBULATORY SURGICAL CENTER	115.00	746, 443	0			2.00
2.00	(D. P.)	113.00	740, 443	U			2.00
3. 00	PHYS THERAPY PERFORMANCE	194. 00	1 040 011	0			3 00
3.00	CENTER PERFORMANCE	194.00	1, 060, 011	U			3. 00
	CENTER — — — —	+	7, 071, 215	₀			•
	U DUDCHASED SERVICES		7,071,213	U			
1 00	H - PURCHASED SERVICES ADMINISTRATIVE & GENERAL	5. 00	1 071 227	0			1 00
1.00			1, 071, 337	0			1.00
2.00	OPERATION OF PLANT	7. 00	152, 152	0			2.00
3.00	HOUSEKEEPI NG	9.00	64, 324	0			3.00
4.00	DI ETARY	10.00	239, 939	0			4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	29, 727	0			5.00
6.00	PHARMACY	15. 00	12, 393	0			6. 00
7.00	ADULTS & PEDIATRICS	30. 00	6, 167	0			7. 00
8.00	OPERATING ROOM	50. 00	1, 033, 667	0			8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54. 00	84, 416	0			9. 00
10.00	LABORATORY	60.00	429, 348	0			10.00
11. 00	RESPI RATORY THERAPY	65. 00	72, 988	0			11.00
12.00	DRUGS CHARGED TO PATIENTS	7300	51 <u>8,</u> 969	0			12. 00
	0		3, 715, 427				
	I - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO	72.00	0	22, 327, 400			1.00
	PATI ENTS						
				22, 327, 400			
	J - ANESTHESI A	<u>'</u>	<u>'</u>				
1.00	ANESTHESI OLOGY	53.00	0	668, 759			1.00
		 		668, 759			
	L - BONUS DOLLARS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	544, 331	Ω			1.00
	0	— — " " 	544, 331	0			
500 00	Grand Total: Increases		13, 345, 959	50, 014, 383			500.00
550.00	o. and rotar. Theredaes	I	10,040,707	55, 517, 505			1 300. 00

Heal th	Financial Systems	OR	THOPAEDIC HOSP	T. AT PARKVIEW		In Lieu of Fo	orm CMS-2552-10
RECLAS	SIFI CATIONS			Provider CCN: 15-016			heet A-6
						/01/2018 /31/2018 Date/T	Time Prepared:
		D				5/28/2	2019 3: 49 pm
	Cost Center	Decreases Li ne #	Sal ary	Other Wkst. A-7	Ref		
	6.00	7.00	8. 00	9. 00 10. 00			
	A - BUILDING DEPRECIATON		9.99				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	_1, 023, 642	9		1.00
	0		0	1, 023, 642			
	B - MED AND IV SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	68, 731	0		1. 00
2.00	OPERATING ROOM	50.00	0	25, 907, 198	0		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	943	0		3.00
4. 00	MRI	<u>58.</u> 00		<u>4, 040</u> 	0		4. 00
	C - TELEPHONE EXPENSE		U _I	25, 960, 912			
1.00	OPERATING ROOM	50.00	0	1, 565	0		1.00
2. 00	PHYS THERAPY PERFORMANCE	194. 00	ő	12, 105	o		2. 00
	CENTER			,			
	0			13, 670			
	D - PTO PAID						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	147, 103	0	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0	0		6. 00 7. 00
8. 00	+	0.00	0	0	0		8.00
9. 00		0.00	0	0	0		9. 00
7.00			147, 103		4		7.00
	E - PTO EARNED		117, 100	<u> </u>			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 867, 883	0	0		1.00
2.00		0.00	0	О	О		2. 00
3.00		0.00	O	О	o		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8.00		0.00	0	0	0		8. 00
9. 00		0.00	1, 867, 883	0	4		9. 00
	F - HOME OFFICE		1,007,003	0			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 264, 761	0		1.00
2. 00	AMBULATORY SURGI CAL CENTER	115. 00	ő	746, 443	o		2. 00
	(D. P.)						
3.00	PHYS THERAPY PERFORMANCE	194. 00	O	1, 060, 011	О		3. 00
	CENTER						
	0		0	7, 071, 215			
4 00	H - PURCHASED SERVICES	F 00		4 074 007			
1.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00	0	1, 071, 337	0		1.00
2. 00 3. 00	HOUSEKEEPI NG	7. 00 9. 00	0	152, 152 64, 324	o		2. 00 3. 00
4.00	DI ETARY	10. 00	0	239, 939	o		4.00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	29, 727	o		5. 00
6. 00	PHARMACY	15. 00	o	12, 393	ol		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	o	6, 167	o		7. 00
8.00	OPERATING ROOM	50.00	O	1, 033, 667	o		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	o	84, 416	О		9. 00
10.00	LABORATORY	60.00	0	429, 348	0		10.00
11.00	RESPIRATORY THERAPY	65. 00	O	72, 988	0		11. 00
12. 00	DRUGS CHARGED TO PATIENTS		•	518, 969	0		12. 00
	U LMDLANTS		0	3, 715, 427			
1. 00	I - IMPLANTS MEDICAL SUPPLIES CHARGED TO	71.00	ol	22, 327, 400	0		1.00
1.00	PATIENT	71.00	٩	22, 321, 400	ا		1.00
	0 +	+		22, 327, 400			
	J - ANESTHESIA		۷	_2,52., .50			
1.00	OPERATING ROOM	50.00	0	668, 759	0		1.00
		+	0	668, 759			
	L - BONUS DOLLARS RECLASS	<u>'</u>		•			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	544, 331	0	0		1. 00
	0		544, 331	0			
500.00	Grand Total: Decreases		2, 559, 317	60, 801, 025			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0167 Peri od: Worksheet A-7 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 3:49 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 0 2.00 Land Improvements 0 0 2.00 3.00 9, 446, 043 3.00 Buildings and Fixtures Ω 0 0 4.00 Building Improvements 6, 304, 260 130 130 0 4.00 5.00 Fixed Equipment 8, 786, 262 0 5.00 0 6.00 Movable Equipment 9, 751, 165 494, 953 494, 953 361, 171 6.00 0 7.00 58, 642 HIT designated Assets 3, 452, 540 58, 642 0 7.00 8.00 Subtotal (sum of lines 1-7) 37, 740, 270 553, 725 553, 725 361, 171 8.00 9.00 Reconciling Items -452, 457 -1, 755, 886 0 -1, 755, 886 9.00 38, 192, 727 2, 309<u>,</u> 611 Total (line 8 minus line 9) 2, 309, 611 10.00 0 361, 171 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 2.00 Land Improvements 2.00 3.00 Buildings and Fixtures 9, 446, 043 765, 352 3.00 4.00 Building Improvements 6, 304, 390 572, 916 4.00 5.00 Fi xed Equipment 8, 786, 262 44, 171 5.00 Movable Equipment 9, 884, 947 6.00 6, 773, 818 6.00 7.00 HIT designated Assets 7.00 3, 511, 182 Ω

37, 932, 824

-2, 208, 343

40, 141, 167

8, 156, 257

8, 156, 257

Heal th	n Financial Systems C	ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0167	Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
						5/28/2019 3:4	
SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	2, 273, 979	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, 273, 979	0)	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 273, 979			·	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	2, 273, 979				3. 00
		,		•			

Heal th	n Financial Systems (ORTHOPAEDIC HOSI	PT. AT PARKVIEW		In Lieu of Form CMS-25		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/28/2019 3:49	
		COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description		Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	24, 536, 692	0	24, 536, 69	2 0. 657502	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	13, 396, 129	l e				2. 00
3.00	Total (sum of lines 1-2)	37, 932, 821					3. 00
		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	
		6.00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 1, 250, 337	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 023, 642		2. 00
3. 00	Total (sum of lines 1-2)	0	0	<u> </u> JMMARY OF CAPI	0 2, 273, 979	0	3. 00
				JIMIMARY OF CAPT			
	Cost Center Description	Interest	Insurance (see instructions)	,	Capi tal -Relate d Costs (see	Total (2) (sum of cols. 9 through 14)	
					instructions)		
	DART III DECONOLILATION OF CARLTAL COCTO	11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 0	1, 250, 337	1. 00
2.00	CAP REL COSTS-BLDG & FIXT				0 0	1, 250, 337	2. 00
3.00	Total (sum of lines 1-2)				0 0	2, 273, 979	
2.00	1 (1	'	1	-1	_, _,,,,,	2.00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0167

	To 12/31/2018						pared:
				Expense Classification on	Worksheet A	5/28/2019 3: 49	9 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		_				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
	suppliers (chapter 8)						
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	О	9. 00
10. 00	Provider-based physician adjustment	A-8-2	0			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	7, 545, 181			0	12. 00
	transactions (chapter 10)	7.01	7,010,101			Ĭ	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee	1	0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		O		0.00		10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
17.00	pati ents		O		0.00		17.00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	О	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments	ή					
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0. 00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33 ∩∩	Depreciation and Interest OTHER OPERATING REVENUE	В	_7 063	ADMINISTRATIVE & GENERAL	5. 00		33. 00
	TOTAL OF EIGHT NO REVENUE	1 0	-1, 702	PIONINI STICKTI VE & SENERAL	5.00	ા	

				To	o 12/31/2018	Date/Time Pre 5/28/2019 3:4	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
		5 , (0 , (0)			"		
	Cost Center Description	Basi s/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
34.00	OTHER OPERATING REVENUE	В	-674	DRUGS CHARGED TO PATIENTS	73. 00	0	34. 00
35.00	SELF INSURANCE OFFSET	A	-334, 205	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35. 00
36.00	NON ALLOWABLE LOBBY EXPENSE	A	-5, 708	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
37.00	TELEMETRY	A	3, 329	ADULTS & PEDIATRICS	30.00	0	37. 00
38.00	OTHER OPERATING REVENUE	В	-1, 930	OPERATING ROOM	50.00	0	38. 00
39.00	OTHER OPERATING REVENUE	В	-150	PHYS THERAPY PERFORMANCE	194.00	0	39. 00
				CENTER			
40.00	NON ALLOWABLE LOBBY EXPENSES	A	-10	OPERATING ROOM	50.00	0	40.00
41.00	NON ALLOWABLE LOBBY EXPENSES	l A	-1, 250	AMBULATORY SURGICAL CENTER	115.00	0	41.00
				(D. P.)			
42.00	PHYSICIAN ADD BACK	A	213, 963	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
43.00	REMOVE HAF TAX	A	-1, 487, 206	ADMINISTRATIVE & GENERAL	5. 00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49)		5, 923, 378				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

 p		amile i and of 27 the amedite at enable eneath be that eated in certain i of the parti-							
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

6.00	В	0.00	PARKVIEW 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:

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

line 12.

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

Heal th	lealth Financial Systems			ORTHOPAEDI C HOSPT. AT PARKVI EW					In Lieu of Form CMS-2552-10		
STATEME	NT OF COSTS OF	SERVICES FRO	OM RELATED	ORGANI ZATI ONS	AND HOME	Provi der CCN:	15-0167	Peri od:	Worksheet A-8	8-1	
OFFI CE	COSTS							From 01/01/2018 To 12/31/2018	Date/Time Pro 5/28/2019 3:4		
	Net	Wkst. A-7 Re	f.								
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCURI	RED AND ADJU	STMENTS RE	QUI RED AS A RES	ULT OF TRA	NSACTIONS WITH	RELATED C	ORGANIZATIONS OR	CLAI MED		
	HOME OFFICE COS	STS:									
1.00	6, 883, 752		0							1.00	
2.00	97, 075		o							2.00	
3.00	1, 665, 560		o							3.00	
4.00	-1, 101, 206		o							4.00	
5.00	7, 545, 181									5. 00	
* The	amounts on line	es 1-4 (and s	subscripts	as appropriate) are tran	sferred in deta	ail to Wor	ksheet A, column	6, lines as		
								ganization or hom		whi ch	

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)		
and/or Home Office		
Type of Business		
Type of Business		
6. 00		1
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HEALTH SYSTEM	6.	5. 00
7.00	ORTHOPAEDIC SERVICES	7.	7. 00
8.00		8.	3. 00
9.00		9.	9. 00
10.00		10.). 00
100.00		100.). 00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0167 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 3:49 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 250, 337 1 250 337 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,023,642 1, 023, 642 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 906, 818 4, 906, 818 4.00 00500 ADMINISTRATIVE & GENERAL 21, 256, 911 1, 179, 675 5 00 288, 869 35 707 22, 761, 162 5 00 00700 OPERATION OF PLANT 7.00 897, 588 336, 829 22, 227 1, 256, 644 7.00 8.00 00800 LAUNDRY & LINEN SERVICE C 8.00 9.00 00900 HOUSEKEEPI NG 651, 954 0 0 55, 483 707, 437 9.00 01000 DI ETARY 10 00 239, 939 35, 051 10 00 Ω 34 275, 024 11.00 01100 CAFETERI A 0 Ω 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 0 0 12.00 01300 NURSING ADMINISTRATION 13.00 0 13.00 0 0 0 01400 CENTRAL SERVICES & SUPPLY 34,070 14.00 29 727 0 4.343 14 00 15.00 01500 PHARMACY 12, 393 0 1,810 14, 203 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 39.456 311, 027 17.00 271, 571 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19 00 0 20.00 02000 NURSING SCHOOL 20.00 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 155, 772 345, 155 33, 386 400, 033 3, 934, 346 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 10, 370, 656 573, 685 217, 025 1, 009, 250 12, 170, 616 50.00 05300 ANESTHESI OLOGY 53.00 944, 841 40, 131 984, 972 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 83, 822 0 12, 332 96, 154 54.00 58.00 05800 MRI 716, 664 24,098 129, 346 71.036 941, 144 58.00 513, 197 06000 LABORATORY 450, 477 62, 720 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 C 0 Ω 62.30 65.00 06500 RESPIRATORY THERAPY 82.988 0 10, 662 93, 650 65.00 06600 PHYSI CAL THERAPY 948, 963 66, 00 18, 530 389 136, 202 1, 104, 084 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 483 C 483 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 653, 512 3, 653, 512 71.00 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 327, 400 0 0 0 22, 327, 400 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 115, 376 31, 539 87, 010 2, 233, 925 73.00 07697 CARDIAC REHABILITATION 76. 97 76 97 0 Ω 0 0 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 0 C 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 n n 90 00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 10, 194, 538 129, 121 583, 253 10, 906, 912 115. 00 SUBTOTALS (SUM OF LINES 1 through 117) 85, 586, 372 1, 250, 337 118.00 913, 376 3, 750, 674 84, 319, 962 118. 00 NONREIMBURSABLE COST CENTERS 17, 260, 726 194. 00 194. 00 07951 PHYS THERAPY PERFORMANCE CENTER 15, 994, 316 110, 266 1, 156, 144 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 101, 580, 688 1, 250, 337 1, 023, 642 4, 906, 818 101, 580, 688 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0167

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/28/2019 3: 49 pm | Prepared | P

						5/28/2019 3:4	9 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	22, 761, 162					5. 00
7. 00	00700 OPERATION OF PLANT	362, 889					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	302,007	1,017,000	1			8.00
9. 00	00900 HOUSEKEEPI NG	204, 291			911, 728		9. 00
10. 00	01000 DI ETARY	79, 420			911, 720	254 444	
	l I	79, 420	1	1	U	354, 444	
11.00	01100 CAFETERI A	0	0	0	0	0	
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
13. 00	01300 NURSING ADMINISTRATION	0	0	1	0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 839	l	1	0	0	
15.00	01500 PHARMACY	4, 101	0	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17.00	01700 SOCIAL SERVICE	89, 817	0	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	l 0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	Ö	Ö	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	ĺ			0	23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0			U U	U	25.00
30. 00	03000 ADULTS & PEDIATRICS	1, 136, 145	581, 392	Ιο	227 200	354, 444	30.00
30.00		1, 130, 145	581, 392] 0	327, 299	354, 444	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	0 544 500	0// 00/	1	E44.00/	0	F0 00
50. 00	05000 OPERATI NG ROOM	3, 514, 582				0	
53.00	05300 ANESTHESI OLOGY	284, 436				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	27, 767	0	-		0	54. 00
58. 00	05800 MRI	271, 780		0	22, 852	0	58. 00
60.00	06000 LABORATORY	148, 199	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	27, 044	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	318, 833	31, 213	l 0	17, 571	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	139			0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 055, 047	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 447, 592	0	١	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	645, 104	١		0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	045, 104			0	0	
			0		0	_	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	ľ		U	0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	_	_	_		_	4
90. 00	09000 CLI NI C	0	0	0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	3, 149, 654	0	0	0	0	115. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17, 776, 679	1, 619, 533	0	911, 728	354, 444	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	4, 984, 483	0	0	0	0	194. 00
200.00]	1			200. 00
201.00	, ,	0	٥ .	0	n	n	201. 00
202.00		22, 761, 162	1, 619, 533			354, 444	
202.00	1 1 1 1 1 2 (Sam 1 1 1 1 5 1 1 5 Cm Sagit 201)	227,3.7102	1 ., 5 . , , 600		, , , , , , , , , , , , , , , , , , , ,	33., 111	,

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0167

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/28/2019 3:49 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 11.00 12.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 0000000000 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 43, 909 14.00 15.00 01500 PHARMACY 18, 304 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16,00 0 0 0 01700 SOCIAL SERVICE 0 17.00 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 02000 NURSI NG SCHOOL 0 0 20.00 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 21 00 0 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 0 50.00 0 53.00 05300 ANESTHESI OLOGY 000000000000000 Ω 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 0 54.00 58.00 05800 MRI 0 0 0 58.00 0 60.00 06000 LABORATORY 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 0 62.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 06500 RESPIRATORY THERAPY 0 65.00 0 0 0 65.00 66 00 06600 PHYSI CAL THERAPY Ω 0 0 66 00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 0 43, 909 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS Ω 0 18, 304 73 00 0 07697 CARDIAC REHABILITATION 0 76.97 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76.99 07699 LI THOTRI PSY 0 0 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115 00 SUBTOTALS (SUM OF LINES 1 through 117) 43, 909 18, 304 118. 00 118.00 0 0 0 NONREI MBURSABLE COST CENTERS 194. 00 07951 PHYS THERAPY PERFORMANCE CENTER 0 194, 00 0 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 43, 909 18, 304 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0167

					'	0 12/31/2010	5/28/2019 3: 4	9 pm
	·						INTERNS &	
							RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	SERVI CE	NONPHYSICIAN	NURSING SCHOOL		
		RECORDS &			ANESTHETI STS		Y & FRINGES	
		LI BRARY					APPRV	
		16. 00	17	7. 00	19. 00	20. 00	21.00	
	GENERAL SERVICE COST CENTERS	10.00		. 00	17.00	20.00	21.00	
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		4					•	1
7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4					•	5. 00 7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE							8.00
9.00	00900 HOUSEKEEPI NG							9. 00
10.00	01000 DI ETARY							10.00
11. 00	01100 CAFETERI A							11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL							12. 00
13. 00	01300 NURSING ADMINISTRATION							13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY							14. 00
15. 00	01500 PHARMACY							15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	C						16. 00
17.00	01700 SOCIAL SERVICE	C		400, 844				17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	C		0	(19. 00
20.00	02000 NURSI NG SCHOOL	l c	ol .	0		0		20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV			0			0	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
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1				1	20.00
30. 00	03000 ADULTS & PEDIATRICS	C	ol	400, 844		0	0	30. 00
	ANCILLARY SERVICE COST CENTERS		1	,		-		1
50.00	05000 OPERATI NG ROOM	C		0		0	0	50.00
53.00	05300 ANESTHESI OLOGY			0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0	•		l .	54.00
58. 00	05800 MRI		d	0	•		Ō	58. 00
60.00	06000 LABORATORY		d	0				60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0				62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			0	1	-	_	62. 30
65. 00	06500 RESPIRATORY THERAPY			0		-	_	65. 00
66. 00	06600 PHYSI CAL THERAPY			0	•			66. 00
69. 00	06900 ELECTROCARDI OLOGY			0			_	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1	0				71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0	•			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			0				73.00
76. 97	07500 DRUGS CHARGED TO PATTENTS		1	0				76. 97
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY		()	0	1	-	_	76. 97
76. 99	07699 LI THOTRI PSY	C	4	0		0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS	1						00.00
90.00	09000 CLINIC	C	1	0	(0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART							92. 00
445.00	SPECIAL PURPOSE COST CENTERS				1			445 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	C	1	0				115. 00
118.00		C	1	400, 844		0	0	118. 00
104.00	NONREI MBURSABLE COST CENTERS							104 00
	07951 PHYS THERAPY PERFORMANCE CENTER		'	0				194. 00
200.00	, ,			_	(_	200.00
201.00	3		']	400 044	(201. 00
202.00	TOTAL (sum lines 118 through 201)	C	וי	400, 844	(0	ll O	202. 00

Health Financial Systems	ORTHOPAEDIC HOSP	T. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B	
				To 12/31/2018	Date/Time Pre 5/28/2019 3:4	pared:
	INTERNS &				3/20/2019 3.4	7 DIII
	RESI DENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
oost conton bood (ptron	PRGM COSTS	PRGM	oub to tu.	Residents Cost	10 tu	
	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 & FLXT						1.00
2.00 O0200 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 CAFETERIA						11.00
12. 00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00 01700 SOCIAL SERVICE						17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS						19. 00
20. 00 02000 NURSI NG SCHOOL						20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o					22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)		O				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	0	0	6, 734, 47	70 0	6, 734, 470	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	17, 195, 54	10 0	17, 195, 540	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	1, 269, 40	0 8	1, 269, 408	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	123, 92	21 0	123, 921	54.00
58. 00 05800 MRI	0	0	1, 276, 36	68 0	1, 276, 368	58. 00
60. 00 06000 LABORATORY	0	0	661, 39	96 0	661, 396	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	120, 69	94 0	120, 694	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1, 471, 70	01 0	1, 471, 701	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	62	22 0	622	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4, 708, 5	59 0	4, 708, 559	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	28, 818, 90	01 0	28, 818, 901	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	2, 897, 33	33 0	2, 897, 333	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	14, 056, 56	56 0	14, 056, 566	115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0	0	79, 335, 47	79 0	79, 335, 479	118. 00
NONREI MBURSABLE COST CENTERS						
194.00 07951 PHYS THERAPY PERFORMANCE CENTER	0	0	22, 245, 20	0		1
200.00 Cross Foot Adjustments	0	0		0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	O	101, 580, 68	38 0	101, 580, 688	202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0167

				Io	12/31/2018	Date/lime Pre 5/28/2019 3:4	
			CAPLTAL REI	LATED COSTS		372072017 3.4	7 pili
			ON TIME KE	EXTED COOTS			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs				DEI / III CIIII EI CI	
		0	1. 00	2.00	2A	4. 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	0	0	0	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 552, 497	288, 869	35, 707	2, 877, 073	0	5. 00
7.00	00700 OPERATION OF PLANT	0	0	336, 829	336, 829	0	7. 00
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	O	0	34	34	0	10. 00
11.00	01100 CAFETERI A	o	0	0	0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	o	0	0	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	o	0	0	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	Ö	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	0	345, 155	33, 386	378, 541	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	573, 685	217, 025	790, 710	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	24, 098	129, 346	153, 444	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	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	18, 530	389	18, 919	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	31, 539	31, 539	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	1	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0	90. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
115 00	SPECIAL PURPOSE COST CENTERS		0	120 121	120 121	0	115 00
118.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	1 250 227		129, 121		115. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 552, 497	1, 250, 337	913, 376	4, 716, 210	0	118. 00
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	0	0	110, 266	110, 266	0	194. 00
200.00			0	110, 200	110, 200	0	200. 00
201.00	1 1		0	0	0	n	201. 00
202.00	1 1 3	2, 552, 497	1, 250, 337	1	4, 826, 476		202. 00
_52.00	1 - 1.57.12 (54 1.1.155 116 till 64gil 251)	_, _, _, , , , , ,	., 200, 007	1 ., 525, 542	., 525, 176	·	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ORTHOPAEDI C HOSPT. AT PARKVI EW Provider CCN: 15-0167

				'	0 12/01/2010	5/28/2019 3:4	9 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 877, 073					5. 00
7. 00	00700 OPERATION OF PLANT	45, 870	382, 699				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	10,070	002, 077				8. 00
9. 00	00900 HOUSEKEEPING	25, 823	0	_			9. 00
10. 00	01000 DI ETARY	10, 039	0	0			10.00
11. 00	01100 CAFETERI A	10,037	0	0		0,075	11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0		0	12.00
		0	0		_		1
13.00	01300 NURSI NG ADMI NI STRATI ON	1 244	0	0	-	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 244	0	1	-	0	14.00
15. 00	01500 PHARMACY	518	0	1	_	0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0		0	16. 00
17. 00	01700 SOCIAL SERVICE	11, 353	0	0		0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	_	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	_	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	143, 611	137, 384	0	9, 270	10, 073	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	444, 252	228, 347				50. 00
53.00	05300 ANESTHESI OLOGY	35, 953	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 510	0	0	0	0	54.00
58.00	05800 MRI	34, 354	9, 592	0	647	0	58. 00
60.00	06000 LABORATORY	18, 733	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	3, 418	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	40, 301	7, 376	0	498	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	18	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	133, 360	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	814, 998	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	81, 543	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0.75.0	0	Ö	_	Ö	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	Ö	_	Ö	76. 98
76. 99	07699 LI THOTRI PSY		0		-	-	76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS	<u>۱</u>			J		70.77
90. 00	09000 CLINIC	O	0	0	0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	i i	O	Ĭ	J	Ĭ	92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	398, 124	0	0	0	0	115. 00
118.00	1 1	2, 247, 022	382, 699		-	10, 073	
1 10.00	NONREI MBURSABLE COST CENTERS	2, 241, 022	302, 077		25,025	10,073	1110.00
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	630, 051	0	0	0	n	194. 00
200.00	1	030, 031	0				200.00
200.00	1 1		^	0	0	_	200.00
201.00		2, 877, 073	382, 699		_		
202.00	TOTAL (Suil TITIES TTO THE OUGH 201)	2,011,013	302, 099	1	25, 025	10,073	1202.00

Heal th Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0167
From 01/01/2018
To 12/31/2018
Date/Time Prepared:

				10	12/31/2010	5/28/2019 3: 4	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
	·		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		11. 00	12.00	13. 00	14.00	15. 00	
	GENERAL SERVICE COST CENTERS						1
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						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 MAI NTENANCE OF PERSONNEL	0	C	1			12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	C	0			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	C	0	1, 244		14. 00
15. 00	01500 PHARMACY	0	C	0	0	518	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	C	1	0	0	
17. 00	01700 SOCIAL SERVICE	0	C	1	0	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	
20.00	02000 NURSI NG SCHOOL	0	C	1	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	C	٦ - ١	0	0	
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	C	-	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	C	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_			ام		
30. 00	03000 ADULTS & PEDI ATRI CS	0	C	0	0	0	30.00
FO 00	ANCILLARY SERVICE COST CENTERS	0		J	ما		F0 00
50.00	05000 OPERATING ROOM	0			0	0	1
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	
54.00		0	_	-	0	0	
58. 00	05800 MRI	0	C	-	0	0	
60.00	06000 LABORATORY	0	C	1	0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	1	0	0	
65. 00	06500 RESPIRATORY THERAPY	0	_	٦ - ١	٩	0	
66.00	06600 PHYSI CAL THERAPY	0	C	1	0	0	66.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY	0		1	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0		1	1, 244	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			1, 244	518	1
76. 97	07500 DRUGS CHARGED TO PATTENTS	0		1	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		1	0	0	1
76. 99	07699 LI THOTRI PSY	0			0	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	0		ıj U		0	70. 99
90. 00	09000 CLINIC	0	C	0	O	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			O	O	92.00
72.00	SPECIAL PURPOSE COST CENTERS			l l			72.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	ol ol	0	0	115. 00
118.00		0	_		1, 244		118. 00
110.00	NONREI MBURSABLE COST CENTERS	0		η U _Ι	1, 244	310	11 10.00
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	0	C	ol ol	0	0	194. 00
200.00						0	200. 00
201.00	1 1	n	C	o	n	0	201. 00
202.00		0	_	-	1, 244		202. 00
	1 1 1 1 2 (04 11 11 10 1 10 1 11 0 0 0 0 1		٠ -	1	., =	010	1-32. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0167

					o 12/31/2018	Date/lime Prep 5/28/2019 3:49	
						INTERNS &	7 pili
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG SCHOOL		
		RECORDS &		ANESTHETI STS		Y & FRINGES	
		LI BRARY				APPRV	
	DENERAL DERIVISE DOOT DENTERO	16. 00	17. 00	19. 00	20. 00	21. 00	
1 00	GENERAL SERVICE COST CENTERS		1	I			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00 2. 00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT		-				4.00
5.00	00500 ADMINISTRATIVE & GENERAL		1				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	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	C)				16. 00
17. 00	01700 SOCIAL SERVICE	C	11, 353				17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C	0	1			19. 00
20. 00	02000 NURSI NG SCHOOL	C	0		0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	C	0			0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	0				22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	C	0				23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	C	11, 353	I			30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS		11, 333				30.00
50. 00	05000 OPERATING ROOM	C	0				50. 00
53. 00	05300 ANESTHESI OLOGY	Č	-	•			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	Ċ	Ö	•			54. 00
58.00	05800 MRI	C	0				58. 00
60.00	06000 LABORATORY	C	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0				62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0				62. 30
65. 00	06500 RESPI RATORY THERAPY	C	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	C	0				66. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0				73. 00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON		0				76. 97 76. 98
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY						76. 98 76. 99
70. 99	OUTPATIENT SERVICE COST CENTERS		0				70. 99
90. 00	09000 CLINIC	C	0				90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0				115. 00
118.00	1 1	d			0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	C	0				194. 00
200.00	Cross Foot Adjustments			[c	0	ol	200. 00
201.00	1 1 3	C	0	C			201. 00
202.00	TOTAL (sum lines 118 through 201)	[C	11, 353	[c	0	0	202. 00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0167	Peri od:	Worksheet B	
					From 01/01/2018	Part II	
					To 12/31/2018	Date/Time Pre	pared:
		LATERNIC 0				5/28/2019 3:4	9 pm
		I NTERNS &					
	C+ C+	RESI DENTS	DADAMED ED	C	1 4 0	T-4-1	
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS	PRGM		Residents Cost		
		APPRV			& Post		
					Stepdown		
		00.00	00.00	04.00	Adjustments	07.00	
	CENEDAL CEDVICE COCT CENTERS	22. 00	23. 00	24. 00	25. 00	26. 00	
4 00	GENERAL SERVICE COST CENTERS			1			4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE						17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00	02000 NURSI NG SCHOOL						20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV						21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0					22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	١	0				23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						25.00
30. 00	03000 ADULTS & PEDI ATRI CS			690, 23	2 0	690, 232	30.00
00.00	ANCI LLARY SERVI CE COST CENTERS			0,0,20		0,0,202	00.00
50. 00	05000 OPERATING ROOM			1, 478, 71	7 0	1, 478, 717	50.00
53. 00	05300 ANESTHESI OLOGY			35, 95			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			3, 51		3, 510	54.00
58. 00	05800 MRI			198, 03		198, 037	58.00
60. 00	06000 LABORATORY			18, 73		18, 733	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			10, /3	0 0	16, 733	62.00
	1 1				ا ا		•
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			2 41	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY			3, 41		3, 418	65.00
66.00	06600 PHYSI CAL THERAPY			67, 09		67, 094	66.00
69. 00	06900 ELECTROCARDI OLOGY				8 0	18	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			133, 36		133, 360	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS			816, 24		816, 242	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS			113, 60		113, 600	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON				0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY				0 0		76. 98
76. 99	07699 LI THOTRI PSY				0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C				0		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)			527, 24	5 0	527, 245	115. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	4, 086, 15	9 0	4, 086, 159	118. 00
	NONREI MBURSABLE COST CENTERS						
194.00	07951 PHYS THERAPY PERFORMANCE CENTER			740, 31	7 0	740, 317	194. 00
200.00	Cross Foot Adjustments	0	0		0 0	0	200. 00
201.00	Negative Cost Centers	0	0		0 0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	0	4, 826, 47	6 0	4, 826, 476	202. 00
	•	. '		•		-	•

			KINUPAEDIC NUSI		ON 15 01/7 5		W	
COST A	LLUCAI	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
						From 01/01/2018 o 12/31/2018		norod.
					'	0 12/31/2018	Date/Time Pre 5/28/2019 3:4	
			CADITAL DEL	LATED COSTS			3/20/2019 3.4	9 pili
			CAPITAL REL	LATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
			((DEPARTMENT		(ACCUM. COST)	
					(GROSS		(71000MI. 0001)	
					SALARI ES)			
			1. 00	2. 00	4.00	5A	5. 00	
	GENER/	AL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	80, 837					1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP	,	2, 833, 612				2. 00
				2,033,012				
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	33, 589, 328			4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	18, 676	98, 844	8, 075, 451	-22, 761, 162	78, 819, 526	5. 00
7.00	00700	OPERATION OF PLANT	0	932, 399	152, 152	0	1, 256, 644	7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
9. 00		HOUSEKEEPI NG	٥	ا م	379, 802	-	707, 437	
	1		0	0				
10. 00		DI ETARY	0	93	239, 939			
11. 00	01100	CAFETERI A	0	0	(0	0	11. 00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00		NURSI NG ADMINI STRATI ON	n	l o	1	0	l 0	1
	1		0		20. 725	-		
		CENTRAL SERVICES & SUPPLY	0	0	29, 727		34, 070	
15. 00		PHARMACY	0	0	12, 393	0	14, 203	15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	0	(0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	270, 096	0	311, 027	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	ا ا		0	0	1
			0				1	
20. 00		NURSING SCHOOL	0	0		0	0	
21.00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21. 00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22. 00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	1	0	0	23. 00
20.00		ENT ROUTINE SERVICE COST CENTERS				,ı		1 20.00
20.00			22.215	00.410	2 720 20/		2 024 244	1 20 00
30. 00		ADULTS & PEDI ATRI CS	22, 315	92, 419	2, 738, 394	0	3, 934, 346	30.00
		_ARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37, 090	600, 761	6, 908, 745	0	12, 170, 616	50.00
53.00	05300	ANESTHESI OLOGY	0	0	274, 714	0	984, 972	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	ا ا	84, 416			
			4 550	050.050				
58. 00	05800		1, 558	358, 050				1
60.00	06000	LABORATORY	0	0	429, 348	0	513, 197	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	l 0	62. 30
65. 00		RESPI RATORY THERAPY	0	ا ا	72, 988	0		
			1 100	1 070				
66. 00		PHYSI CAL THERAPY	1, 198	1, 078	932, 363		.,	
69. 00		ELECTROCARDI OLOGY	0	0	(0	483	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	3, 653, 512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	22, 327, 400	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	87, 306	595, 620	0	2, 233, 925	
			0	07, 300	373, 020			
	1	CARDIAC REHABILITATION	0	0		0	0	
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99	07699	LI THOTRI PSY	0	0		0	0	76. 99
	OUTPA	TIENT SERVICE COST CENTERS			•			1
90.00		CLINIC	0	0	(0	0	90.00
	1					ή	l ⁰	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIA	AL PURPOSE COST CENTERS						
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0			0	10, 906, 912	115. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80, 837	2, 528, 378	25, 675, 034	-22, 761, 162	61, 558, 800	118.00
		MBURSABLE COST CENTERS					, , , , , , , , , , , , , , , , , , , ,	
104 00		PHYS THERAPY PERFORMANCE CENTER	0	205 224	7 014 207	0	17 2/0 72/	1104 00
	1		U	305, 234	7, 914, 294	0	17, 260, 726	1
200.00	1	Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	1, 250, 337	1, 023, 642	4, 906, 818	3	22, 761, 162	202. 00
		Part I)					,	
202 00			15 147205	0.241250	0. 146083		0. 288776	202 00
203.00	1	Unit cost multiplier (Wkst. B, Part I)	15. 467385	0. 361250	0. 140083			
204.00	'	Cost to be allocated (per Wkst. B,			1	ין	2, 877, 073	204.00
		Part II)						
205.00		Unit cost multiplier (Wkst. B, Part			0.000000)	0. 036502	205.00
		11)						1
206.00	d	NAHE adjustment amount to be allocated						206. 00
200.00	1							200.00
007.55		(per Wkst. B-2)						007.00
207.00	'	NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0167 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (MEALS SERVED) PLANT (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 62, 161 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 0 62, 161 9.00 10.00 01000 DI ETARY 0 24, 379 10.00 11.00 01100 CAFETERI A 0000000 0 11.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 12.00 Λ 13.00 01300 NURSING ADMINISTRATION 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 14.00 01500 PHARMACY 0 15.00 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20.00 Ω 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 0 0 22.00 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22, 315 0 22, 315 24, 379 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 37 090 n 37 090 n 50 00 O 0 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 1,558 0 0 0 58.00 1,558 06000 LABORATORY 60 00 Ω 60 00 0 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 0 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 62.30 0 06500 RESPIRATORY THERAPY 65.00 0 \cap 0 65.00 06600 PHYSI CAL THERAPY Ω 66.00 1, 198 1, 198 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 73.00 0 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 07699 LI THOTRI PSY 76.99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 \cap 0 115, 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 62, 161 0 62, 161 24, 379 0 118.00 NONREI MBURSABLE COST CENTERS 0 194. 00 194.00 07951 PHYS THERAPY PERFORMANCE CENTER 0 Ω 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1.619.533 911, 728 354.444 0 202, 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 26.053844 0.000000 14.667203 14. 538906 0.000000 203.00 Cost to be allocated (per Wkst. B, 0 204.00 204.00 382, 699 25, 823 10, 073 Part II) Unit cost multiplier (Wkst. B, Part 0.000000 205.00 205.00 6. 156577 0.000000 0.415421 0.413183 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00

Parts III and IV)

Heal th	Fi nan	cial Systems C	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der C		eriod: com 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre	
		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER	NURSI NG ADMI NI STRATI ON	CENTRAL	PHARMACY (COSTED REQUIS.)	5/28/2019 3: 4 MEDI CAL RECORDS & LI BRARY	
			HOUSED)	(DI RECT NRSI NG			(TIME SPENT)	
			12. 00	HRS) 13. 00	REQUI S.) 14. 00	15. 00	16. 00	
	GENER	AL SERVICE COST CENTERS	12.00	13.00	14.00	13.00	10.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE		•				7. 00 8. 00
9.00	1	HOUSEKEEPING						9. 00
10. 00	1	DI ETARY						10.00
11. 00	01100	CAFETERI A						11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0					12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	0	0	00 050 050			13. 00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	0	22, 953, 958	10, 000		14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY			0	10, 000	0	1
17. 00	1	SOCIAL SERVICE			0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS		Ö	ő	o	0	1
20.00	1	NURSI NG SCHOOL	0	0	0	o	0	20. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	1	I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	0	0	0	ol	0	30.00
30.00		LARY SERVICE COST CENTERS		,,	0	<u> </u>		30.00
50.00		OPERATI NG ROOM	0	0	0	0	0	50.00
53.00		ANESTHESI OLOGY	0	0	0	o	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	1
58. 00	05800	i e e e e e e e e e e e e e e e e e e e	0	0	0	0	0	
60. 00 62. 00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62. 30
65. 00		RESPIRATORY THERAPY			ő	ol	0	65.00
66. 00	1	PHYSI CAL THERAPY	0	0	0	o	0	66. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	_	0	0	
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	22, 953, 958	10,000	0	1
73. 00 76. 97	1	DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION			0	10, 000	0	
76. 98		HYPERBARI C OXYGEN THERAPY			1	Ö	0	1
76. 99		LI THOTRI PSY	0	Ö		ō	0	1
		TIENT SERVICE COST CENTERS						
		CLINIC	0	0	0	0	0	90.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS						92. 00
115 00		AMBULATORY SURGICAL CENTER (D. P.)		0	0	ol	0	115. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)				10, 000		118. 00
		IMBURSABLE COST CENTERS				.,		
		PHYS THERAPY PERFORMANCE CENTER	0	0	0	0	0	194. 00
200.00	1	Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0		42,000	10 204	0	201. 00
202.00	'	Cost to be allocated (per Wkst. B, Part I)		0	43, 909	18, 304	Ü	202. 00
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 001913	1. 830400	0. 000000	203. 00
204.00		Cost to be allocated (per Wkst. B,	0	0	1, 244	518		204.00
		Part II)						
205.00)	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000054	0. 051800	0. 000000	205. 00
206.00		NAHE adjustment amount to be allocated	1					206. 00
		(per Wkst. B-2)						
207.00)	NAHE unit cost multiplier (Wkst. D,						207. 00
	1	Parts III and IV)	1	I	1	I		I

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0167

					o 12/31/2018		
					INTERNS &	5/28/2019 3: 4 RESI DENTS	9 piii
	Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
		17. 00	19.00	20.00	TI ME) 21. 00	TIME) 22.00	
	GENERAL SERVICE 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	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCI AL SERVI CE	10,000					17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	C	, 0			19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0		21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0					23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10,000		J 0	O	0	30. 00
30. 00	ANCILLARY SERVICE COST CENTERS	10,000) 0	ıl U	0	30.00
50.00	05000 OPERATI NG ROOM	0	C) 0	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	0	C			0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C	0		0	54.00
58. 00 60. 00	05800 MRI 06000 LABORATORY	0		0		0	58. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				1	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	C	0		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0		0	66.00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		o o	-	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C	0	1	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0		0	1	0	76. 98 76. 99
70. 99	OUTPATIENT SERVICE COST CENTERS	0		η Ο	ıl Ol	0	70.99
90.00	09000 CLI NI C	0	C) 0	0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
115 00	SPECIAL PURPOSE COST CENTERS	1 0			ا	0	1115 00
118.00	11500 AMBULATORY SURGICAL CENTER (D.P.) SUBTOTALS (SUM OF LINES 1 through 117)	10, 000	-				115. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	10,000		,,	<u> </u>	J	1110.00
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	0	C	0	0	0	194. 00
200.00							200. 00
201.00		400 044	_			0	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	400, 844	C	0	0	0	202. 00
203. 00		40. 084400	0. 000000	0. 000000	0. 000000	0. 000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	11, 353) 0	0		204. 00
	Part II)	4 405000					
205. 00	Unit cost multiplier (Wkst. B, Part	1. 135300	0. 000000	0. 000000	0. 000000	0. 000000	205.00
206. 00		1		0	,		206. 00
	(per Wkst. B-2)						
207. 00				0. 000000			207. 00
	Parts III and IV)	I	I	I			I

Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0167 Period: Worksheet B-1

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17. 00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM O 50 00 05300 ANESTHESI OLOGY 53.00 0000000000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 58.00 05800 MRI 58.00 06000 LABORATORY 60 00 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 76. 97 07697 CARDIAC REHABILITATION 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 07699 LI THOTRI PSY 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 NONREI MBURSABLE COST CENTERS 194. 00 07951 PHYS THERAPY PERFORMANCE CENTER 0 194 00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202. 00 202.00 Cost to be allocated (per Wkst. B, 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203.00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 0 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 207.00 Parts III and IV)

Heal th	Financial Systems (ORTHOPAEDIC HOSI	PT AT PARKVIEW		Inlie	u of Form CMS-:	2552_10
	ATTION OF RATIO OF COSTS TO CHARGES	ACTIONALLI C 11031	Provider CO		Peri od: From 01/01/2018	Worksheet C	pared:
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	6, 734, 470		6, 734, 47	0	6, 734, 470	30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	17, 195, 540		17, 195, 54		17, 195, 540	
	05300 ANESTHESI OLOGY	1, 269, 408		1, 269, 40		1, 269, 408	
	05400 RADI OLOGY-DI AGNOSTI C	123, 921		123, 92		123, 921	
	05800 MRI	1, 276, 368		1, 276, 36		1, 276, 368	
	06000 LABORATORY	661, 396		661, 39	6 0	661, 396	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	02.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30

120, 694

622

0

0

0

0

758, 222

758, 222

14, 056, 566

80, 093, 701

79, 335, 479

1, 471, 701

4, 708, 559

28, 818, 901

2, 897, 333

120, 694

622

0

0

0

0

758, 222

758, 222

14, 056, 566

80, 093, 701

79, 335, 479

0

1, 471, 701

4, 708, 559

2, 897, 333

28, 818, 901

0

0

o

65.00

66.00

69.00

71.00

72.00

73.00

76. 98

76. 99

92.00

120, 694

622

0 76. 97

0

0

0 90.00

14, 056, 566 115. 00

80, 093, 701 200. 00 758, 222 201. 00 79, 335, 479 202. 00

758, 222

1, 471, 701

4, 708, 559

2, 897, 333

28, 818, 901

06500 RESPIRATORY THERAPY

07697 CARDIAC REHABILITATION

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

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

Less Observation Beds

Total (see instructions)

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

06600 PHYSI CAL THERAPY

07699 LI THOTRI PSY

09000 CLI NI C

06900 ELECTROCARDI OLOGY

66.00

69.00

72.00

73.00

76. 97

76. 98

76. 99

90.00

92.00

200.00

201.00

202.00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lieu of Form CMS-2			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 3:49 pm		

				Ť	o 12/31/2018	Date/Time Pre 5/28/2019 3:4	
			Title	XVIII	Hospi tal	PPS	
		Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	8, 657, 958		8, 657, 958			30. 00
	CILLARY SERVICE COST CENTERS						4
	OOO OPERATING ROOM	101, 757, 206	91, 853, 467			0. 000000	
	300 ANESTHESI OLOGY	9, 428, 410	7, 640, 571			0. 000000	
	400 RADI OLOGY-DI AGNOSTI C	1, 628, 221	2, 284, 795			0. 000000	
	800 MRI	28, 735	7, 074, 891			0. 000000	
	000 LABORATORY	2, 263, 825	446, 856	2, 710, 681		0. 000000	
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0. 000000	0. 000000	
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0. 000000	0. 000000	
	500 RESPI RATORY THERAPY	169, 048	30, 024	· ·	1	0. 000000	
	600 PHYSI CAL THERAPY	4, 034, 656	308, 823			0. 000000	
	900 ELECTROCARDI OLOGY	44, 593	30, 448	· ·	1	0. 000000	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 779, 414	11, 935, 767			0. 000000	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	96, 839, 355	25, 551, 441	122, 390, 796	0. 235466	0. 000000	
	300 DRUGS CHARGED TO PATIENTS	13, 944, 336	7, 328, 557	21, 272, 893		0. 000000	73. 00
	697 CARDIAC REHABILITATION	0	0	C	0. 000000	0. 000000	76. 97
	698 HYPERBARIC OXYGEN THERAPY	0	0	C	0. 000000	0. 000000	76. 98
	699 LI THOTRI PSY	0	0	C	0.000000	0. 000000	76. 99
	TPATIENT SERVICE COST CENTERS						
90.00 09	000 CLI NI C	0	0	C	0.000000	0.000000	90. 00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	0	649, 715	649, 715	1. 167007	0. 000000	92. 00
	ECIAL PURPOSE COST CENTERS						
115. 00 11	500 AMBULATORY SURGICAL CENTER (D. P.)	0	90, 782, 516	90, 782, 516			115. 00
200.00	Subtotal (see instructions)	248, 575, 757	245, 917, 871	494, 493, 628			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	248, 575, 757	245, 917, 871	494, 493, 628			202. 00

Heal th	Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVIEW	In Lie	u of Form CMS-	2552-10
СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018		
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 088815				50.00
53.00	05300 ANESTHESI OLOGY	0. 074369				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 031669				54.00
58. 00	05800 MRI	0. 179678				58. 00
	06000 LABORATORY	0. 243996				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000				62. 30
65.00	06500 RESPI RATORY THERAPY	0. 606283				65. 00
	06600 PHYSI CAL THERAPY	0. 338830				66. 00
	06900 ELECTROCARDI OLOGY	0. 008289				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 216833				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 235466				72. 00
72 00	07200 DDUCE CHARCED TO DATIENTE	0 12/100				72 00

0. 136198

0.000000

0. 000000 0.000000

0.000000

1. 167007

73.00

76. 97

76. 98

76. 99

90.00

92.00

115.00

200. 00

202. 00

73.00 07300 DRUGS CHARGED TO PATIENTS

76. 98 07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY

OUTPATIENT SERVICE COST CENTERS

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

76. 97 07697 CARDI AC REHABI LI TATI ON

09000 CLI NI C

90.00

92.00

200.00 201.00

202.00

Health Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 734, 470		6, 734, 47	0 0	6, 734, 470	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	17, 195, 540		17, 195, 54		17, 195, 540	
53. 00 05300 ANESTHESI OLOGY	1, 269, 408		1, 269, 40		1, 269, 408	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	123, 921		123, 92		123, 921	
58. 00 05800 MRI	1, 276, 368		1, 276, 36		1, 276, 368	
60. 00 06000 LABORATORY	661, 396		661, 39	6 0	661, 396	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	120, 694	0	120, 69		120, 694	
66. 00 06600 PHYSI CAL THERAPY	1, 471, 701	0	1, 471, 70		1, 471, 701	
69. 00 06900 ELECTROCARDI OLOGY	622		62	2 0	622	69. 00

Health Financial S	Systems	ORTHOPAEDI C HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-2552-10
COMPUTATION OF RA	TIO OF COSTS TO CHARGES		Provider CCN: 15-0167	From 01/01/2018	Worksheet C Part I Date/Time Prepared:

				j	o 12/31/2018	Date/Time Pre 5/28/2019 3:4	
			Titl	e XIX	Hospi tal PPS		
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00	03000 ADULTS & PEDIATRICS	8, 657, 958		8, 657, 958	3		30. 00
	ANCILLARY SERVICE COST CENTERS						4
50. 00	05000 OPERATING ROOM	101, 757, 206	91, 853, 467			0. 000000	
53. 00	05300 ANESTHESI OLOGY	9, 428, 410	7, 640, 571			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 628, 221	2, 284, 795			0. 000000	
58. 00	05800 MRI	28, 735	7, 074, 891	7, 103, 626		0.000000	
60.00	06000 LABORATORY	2, 263, 825	446, 856	2, 710, 681		0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0.000000	0.000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0.000000	0.000000	62. 30
65. 00	06500 RESPI RATORY THERAPY	169, 048	30, 024	199, 072	0. 606283	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 034, 656	308, 823	4, 343, 479	0. 338830	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	44, 593	30, 448	75, 041	0. 008289	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 779, 414	11, 935, 767	21, 715, 181	0. 216833	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	96, 839, 355	25, 551, 441	122, 390, 796	0. 235466	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 944, 336	7, 328, 557	21, 272, 893	0. 136198	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0.000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0.000000	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0.000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0	(0.000000	0.000000	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	649, 715	649, 715	1. 167007	0.000000	92. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	90, 782, 516	90, 782, 516	b		115. 00
200.00	Subtotal (see instructions)	248, 575, 757	245, 917, 871	494, 493, 628	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	248, 575, 757	245, 917, 871	494, 493, 628	3		202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT			u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 3:4	epared: 19 pm
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVICE COST CENTERS					1 00.00
50. 00 05000 OPERATING ROOM	0. 088815				50.00
53. 00 05300 ANESTHESI OLOGY	0. 074369				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 031669				54.00
58. 00 05800 MRI	0. 179678				58.00
60. 00 06000 LABORATORY	0. 243996				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 RESPIRATORY THERAPY	0. 606283				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 338830				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 008289				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 216833				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 235466				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 136198				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 CLI NI C	0. 000000				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 167007				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

MCRI F32 - 15. 5. 166. 1

Health Financial Systems	ORTHOPAEDI C HOSPT. A	In Lieu of Form CMS-2552-10		
CALCULATION OF OUTPATIENT SERVICE COREDUCTIONS FOR MEDICALD ONLY	OST TO CHARGE RATIOS NET OF	Provider CCN: 15-0167	From 01/01/2018	Worksheet C Part II Date/Time Prepared: 5/28/2019 3:49 pm

				1	0 12/31/2018	5/28/2019 3: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					1	
	05000 OPERATING ROOM	17, 195, 540				0	00.00
	05300 ANESTHESI OLOGY	1, 269, 408	l		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	123, 921		•	0	0	54. 00
	05800 MRI	1, 276, 368			0	0	58. 00
60.00	06000 LABORATORY	661, 396	18, 733	642, 663	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0	0	0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	120, 694		•	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 471, 701			0	0	66. 00
	06900 ELECTROCARDI OLOGY	622	l		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 708, 559				0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	28, 818, 901				0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 897, 333	113, 600	2, 783, 733	0	0	73. 00
	O7697 CARDI AC REHABI LI TATI ON	0	C	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	C	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	C	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	758, 222	77, 712	680, 510	0	0	92. 00
	SPECIAL PURPOSE COST CENTERS						1
	11500 AMBULATORY SURGICAL CENTER (D. P.)	14, 056, 566			0		115. 00
200.00	, ,	73, 359, 231					200. 00
201. 00		758, 222					201. 00
202.00	Total (line 200 minus line 201)	72, 601, 009	3, 395, 927	69, 205, 082	0	0	202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT.	u of Form CMS-2552-10		
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provi der CCN: 15-0167		Worksheet C Part II Date/Time Prepared: 5/28/2019 3:49 pm
		T1 11 1/11/		000

						5/28/2019 3:4	PUII
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and	(Worksheet C,				
			Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
Д	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	17, 195, 540	193, 610, 673	0. 088815	5		50.00
53.00	D5300 ANESTHESI OLOGY	1, 269, 408	17, 068, 981	0. 074369			53. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	123, 921	3, 913, 016	0. 031669			54. 00
58.00	05800 MRI	1, 276, 368	7, 103, 626	0. 179678	3		58. 00
60.00	06000 LABORATORY	661, 396	2, 710, 681	0. 243996			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000			62.00
62. 30	D6250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65.00	06500 RESPIRATORY THERAPY	120, 694	199, 072	0. 606283	3		65.00
66.00	06600 PHYSI CAL THERAPY	1, 471, 701	4, 343, 479	0. 338830			66.00
69.00	06900 ELECTROCARDI OLOGY	622	75, 041	0. 008289			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 708, 559	21, 715, 181	0. 216833	3		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	28, 818, 901	122, 390, 796	0. 235466			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 897, 333	21, 272, 893	0. 136198	3		73.00
76. 97	07697 CARDIAC REHABILITATION	0	0	0. 000000)		76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0. 000000)		76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 000000)		76. 99
C	DUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0	0.000000)		90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	758, 222	649, 715	1. 167007	,		92.00
S	SPECIAL PURPOSE COST CENTERS						1
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	14, 056, 566	90, 782, 516	0. 154838	3		115. 00
200.00	Subtotal (sum of lines 50 thru 199)	73, 359, 231					200.00
201.00	Less Observation Beds	758, 222					201.00
202.00	Total (line 200 minus line 201)	72, 601, 009	485, 835, 670				202. 00
		1		•	1		

Health Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS Provi de			Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B, Part II, col.		Related Cost (col. 1 - col			
	26) 1.00	2.00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	690, 232		690, 23	2 6, 093	113. 28	30.00
200.00 Total (lines 30 through 199)	690, 232	ł	690, 23			200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
LANDATI ENT. DOUTLAND OFFICE OF COOT OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			4
30. 00 ADULTS & PEDI ATRI CS	1, 754		•			30. 00
200.00 Total (lines 30 through 199)	1, 754	198, 693				200. 00

		RTHOPAEDIC HOS			In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/28/2019 3:4	pared: O nm
Title XVIII Hospital PS							
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	, and the second		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,				column 4)	
		Part II, col.	8)	2)		<u> </u>	
		26)	ŕ				
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 478, 717	193, 610, 673	0.00763	8 30, 622, 751	233, 897	50.00
53.00	05300 ANESTHESI OLOGY	35, 953	17, 068, 981	0.00210	2, 864, 468	6, 033	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 510	3, 913, 016	0. 00089	7 485, 854	436	54.00
58.00	05800 MRI	198, 037	7, 103, 626	0. 02787	8 4, 908	137	58. 00
60.00	06000 LABORATORY	18, 733	2, 710, 681	0. 00691	1 708, 805	4, 899	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 RESPIRATORY THERAPY	3, 418	199, 072	0. 01717	0 20, 612	354	65. 00
66.00	06600 PHYSI CAL THERAPY	67, 094	4, 343, 479	0. 01544	7 1, 222, 354	18, 882	66. 00
69.00	06900 ELECTROCARDI OLOGY	18	75, 041	0.00024	0 34, 203	8	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	133, 360	21, 715, 181	0.00614	1 3, 357, 499	20, 618	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	816, 242	122, 390, 796	0. 00666	9 28, 809, 337	192, 129	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	113, 600	21, 272, 893	0.00534	0 4, 089, 732	21, 839	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	76. 98
	07699 LI THOTRI PSY	0	0	0.00000		0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.00000	0 0	0	90. 00
00 00	DOGGO ORGERVATION REPO (NON RICTINGT RAPT	77 740	(40 745	0 44046		1	00 00

77, 712

2, 946, 394

649, 715

395, 053, 154

0 0 72, 220, 523

0. 119609

0 90.00 0 92.00

499, 232 200. 00

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

Health Financial Systems (ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDLATRICS 200. 00 Total (Lines 30 through 199)	0	0		0 0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	6, 09 6, 09			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30. 00 03000 ADULTS & PEDLATRICS	Ι ο					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW				In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY	SERVICE OTHER	PASS	Provider CCN:	15-0167	From 01/01/2018	Worksheet D Part IV Date/Time Prepared:

							5/28/2019 3:4	9 pm
				Titl∈	XVIII	Hospi tal	PPS	
		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Anesthetist	Post-Stepdown		Post-Stepdown		
			Cost	Adjustments		Adjustments		
			1.00	2A	2.00	3A	3. 00	
		ARY SERVICE COST CENTERS						
		OPERATING ROOM	0	0	(0	0	50. 00
	1 1	ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
58.00	05800	MRI	0	0	(0	0	58. 00
60.00	06000	LABORATORY	0	0	(0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62. 00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65.00	06500	RESPI RATORY THERAPY	0	0	(0	0	65. 00
66.00	06600	PHYSI CAL THERAPY	0	0	(0	0	66. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 97	07697	CARDIAC REHABILITATION	0	0	(0	0	76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99	07699	LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPAT	TIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	C	(0	0	90. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92.00
200.00		Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ORTHOPAEDI C HOSPT.	.AT PARKVIEW In Lieu of Form CMS-25			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 3:49 pm	
		Title XVIII	Hospi tal	PPS	

				10 12/31/2018	5/28/2019 3: 49	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	0	0	(193, 610, 673	1	50. 00
53. 00 05300 ANESTHESI OLOGY	0	0	(17, 068, 981	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		3, 913, 016		54. 00
58. 00 05800 MRI	0	0		7, 103, 626	1	58. 00
60. 00 06000 LABORATORY	0	0		2, 710, 681		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0. 000000	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0. 000000	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0		199, 072	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		4, 343, 479		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		75, 041	0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(21, 715, 181		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (122, 390, 796		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0) (21, 272, 893	0. 000000	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0) (0	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0) (0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0)	0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0) (0	0.000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		649, 715		92.00
200.00 Total (lines 50 through 199)	0	0	(395, 053, 154		200. 00

	5	DELIGIATION A LIGGI	T AT DADIUM EW			6.5. 046.4	2550 40
APPORT	Financial Systems C TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	ORTHOPAEDIC HOSP RVICE OTHER PASS			In Lie Period: From 01/01/2018 To 12/31/2018		pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	30, 622, 751		0 15, 534, 605	0	50. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	2, 864, 468		0 1, 199, 678	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	485, 854		0 479, 660	0	54.00
58.00	05800 MRI	0. 000000	4, 908		0 1, 419, 035	0	58. 00
60.00	06000 LABORATORY	0. 000000	708, 805		0 107, 183	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 000000	20, 612		0 2, 514	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 222, 354		0 109, 972	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	34, 203		0 3, 261	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	3, 357, 499		0 2, 036, 608	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	28, 809, 337		0 5, 087, 274	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 089, 732		0 1, 389, 439	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	· · · · ·					
90.00	09000 CLI NI C	0.000000	0		0 0	0	90. 00
00 00	DOGGO ORGERVATION REDG (NON DISTINGT DART	0 000000			404 450		00 00

0.000000

0

72, 220, 523

0 131, 159 27, 500, 388

0 90.00 0 92.00

0 200. 00

0 0 0

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0167 From 01/01/2018 To 12/31/2018 To 12/31/2018 From 01/01/2018 To 12/31/2019 3: 49 pm Title XVIII Hospital PPS Charges Costs	Health Financial Systems	(ORTHOPAEDIC HOS	PT. AT PARKVIEW	. AT PARKVIEW In Li			2552-10
	APPORTIONMENT OF MEDICAL, OT	THER HEALTH SERVICES AND	O VACCINE COST	Provider Co		From 01/01/2018	Part V Date/Time Pre	
Charges Costs			_	Title	: XVIII	Hospi tal	PPS	
					Charges		Costs	

				1	o 12/31/2018	Date/Time Pre 5/28/2019 3:4	pared: 9 pm
			Title	xVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	LARY SERVICE COST CENTERS	_					
	OPERATING ROOM	0. 088815			0	1, 379, 706	1
	ANESTHESI OLOGY	0. 074369	1, 199, 678	(0	89, 219	1
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 031669	479, 660	(0	15, 190	54.00
58.00 05800		0. 179678	1, 419, 035	(0	254, 969	58. 00
60.00 06000	LABORATORY	0. 243996	107, 183	(0	26, 152	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	(0	0	62. 00
62. 30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(0	0	62. 30
65.00 06500	RESPIRATORY THERAPY	0. 606283	2, 514	(0	1, 524	65.00
66.00 06600	PHYSI CAL THERAPY	0. 338830	109, 972	(0	37, 262	66. 00
69.00 06900	ELECTROCARDI OLOGY	0. 008289	3, 261	(0	27	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 216833	2, 036, 608	(0	441, 604	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 235466	5, 087, 274	(0	1, 197, 880	72. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 136198	1, 389, 439	(0	189, 239	73. 00
76. 97 07697	CARDIAC REHABILITATION	0. 000000	0	(0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0. 000000	0	(0	0	76. 98
76. 99 07699	LI THOTRI PSY	0. 000000	0	(0	0	76. 99
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0. 000000	0	(0	0	90. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1. 167007	131, 159	(0	153, 063	92. 00
200. 00	Subtotal (see instructions)		27, 500, 388	(0	3, 785, 835	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		27, 500, 388	(0	3, 785, 835	202. 00

Heal th	Financial Systems	0	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEA	ALTH SERVICES AND	VACCINE COST		CN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 3:4	
			1		XVIII	Hospi tal	PPS	
				sts				
	Cost Center Descriptio	n	Cost	Cost				
			Rei mbursed	Rei mbursed				
			Servi ces	Services Not				
			Subject To Ded. & Coins.	Subject To Ded. & Coins.				
			(see inst.)	(see inst.)				
			6.00	7.00	-			
	ANCILLARY SERVICE COST CENTE	RS	0.00	7.00				
	05000 OPERATI NG ROOM) C				50.00
53.00	05300 ANESTHESI OLOGY							53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C) c				54.00
58.00	05800 MRI		c) c				58. 00
60.00	06000 LABORATORY		() c				60.00
62.00	06200 WHOLE BLOOD & PACKED R	ED BLOOD CELL	C) c				62.00
62. 30	06250 BLOOD CLOTTING FOR HEM	OPHI LI ACS	C	0				62. 30
65.00	06500 RESPI RATORY THERAPY		C) c)			65. 00
	06600 PHYSI CAL THERAPY		C) c)			66. 00
	06900 ELECTROCARDI OLOGY		C) c)			69. 00
	07100 MEDICAL SUPPLIES CHARG		() C)			71. 00
	07200 I MPL. DEV. CHARGED TO		() C)			72. 00
	07300 DRUGS CHARGED TO PATIE		C) C				73. 00
	07697 CARDIAC REHABILITATION		C) C)			76. 97
	07698 HYPERBARI C OXYGEN THER	APY	C) C)			76. 98
76. 99	07699 LI THOTRI PSY		[C) <u> </u> C)			76. 99

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0

0

0

90.00

92.00

200.00

201. 00

202. 00

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

90. 00 09000 CLINIC

Health Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col . 1 - col			
	26)	0.00	2)	4.00	F 00	
LAIDATI ENT. DOUTLAIE CEDIU OF COCT OFNITEDO	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	(00,000		1 (00.00	0 (000	440.00	00.00
30. 00 ADULTS & PEDI ATRI CS	690, 232	ł	690, 23	·	l .	
200.00 Total (lines 30 through 199)	690, 232		690, 23	2 6, 093		200. 00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	62	7, 023		·	·	30.00
200.00 Total (lines 30 through 199)	62	7, 023				200. 00

Health Financial Systems 0	RTHOPAEDI C HOSI	DT AT DADKVIEW		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 0PERATING ROOM	1, 478, 717	193, 610, 673	0.00763	8 224, 272	1, 713	50.00
53. 00 05300 ANESTHESI OLOGY	35, 953		•	·	57	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 510		•		4	54.00
58. 00 05800 MRI	198, 037			· ·	0	58. 00
60. 00 06000 LABORATORY	18, 733	2, 710, 681	0. 00691	1 3, 719	26	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	o	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	o o	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	3, 418	199, 072	0. 01717	o o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	67, 094	4, 343, 479	0. 01544	7 4, 579	71	66. 00
69. 00 06900 ELECTROCARDI OLOGY	18	75, 041	0.00024	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	133, 360	21, 715, 181	0.00614	1 21, 424	132	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	816, 242	122, 390, 796	0. 00666	9 342, 782	2, 286	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	113, 600	21, 272, 893	0.00534	0 41, 613	222	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	0 0	0	76. 97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	77, 712	649, 715	0. 11960	9 0	0	92. 00
200.00 Total (lines 50 through 199)	2, 946, 394	395, 053, 154		669, 756	4, 511	200. 00

Health Financial Systems	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider CO		Period: From 01/01/2018 To 12/31/2018		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	0.00	
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	6, 09 6, 09			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems	0	ORTHOPAEDI C	HOSPT.	AT PARKVIEW	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SER	RVI CE OTHER	PASS	Provi der CCN: 15-0167	From 01/01/2018	Worksheet D Part IV Date/Time Prepared:

							5/28/2019 3:4	9 pm
				Titl	e XIX	Hospi tal	PPS	
		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Anestheti st	Post-Stepdown		Post-Stepdown		
			Cost	Adjustments		Adjustments		
			1.00	2A	2.00	3A	3. 00	
		ARY SERVICE COST CENTERS						
		OPERATING ROOM	0	0	(0	0	50. 00
	1 1	ANESTHESI OLOGY	0	0	(0	0	53. 00
		RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
	05800		0	0	(0	0	58. 00
60.00	06000	LABORATORY	0	0	(0	0	60.00
		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62. 00
		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65.00	06500	RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600	PHYSI CAL THERAPY	0	0	(0	0	66. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 97	07697	CARDIAC REHABILITATION	0	0	(0	0	76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99	07699	LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPAT	TIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	C	(0	0	90. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92.00
200.00		Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	ORTHOPAEDI C HOS	SPT. AT PARKVIEW	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPAT THROUGH COSTS	IENT ANCILLARY SERVICE OTHER PAS	SS Provider CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/28/2019 3:49 pm

			'	0 12/01/2010	5/28/2019 3: 4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS		T				
50. 00 05000 OPERATI NG ROOM	0	0	(193, 610, 673		
53. 00 05300 ANESTHESI OLOGY	0	0	(17, 068, 981		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(3, 913, 016		
58. 00 05800 MRI	0	0	(7, 103, 626		
60. 00 06000 LABORATORY	0	0	(2, 710, 681		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0. 000000	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	(199, 072	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(4, 343, 479	0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(75, 041	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(21, 715, 181	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(122, 390, 796	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(21, 272, 893	0.000000	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	(0	0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0.000000	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0.000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0) (649, 715	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	(395, 053, 154		200. 00

Heal th	Health Financial Systems ORTHOPAEDIC HOSPT.AT PARKVIEW In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS		RVICE OTHER PASS	Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	pared:		
			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		Pass-Through			
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9			
		7)		x col. 10)		x col. 12)			
		9. 00	10. 00	11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS	,				_			
50. 00	05000 OPERATI NG ROOM	0. 000000	224, 272		0	0			
53.00	05300 ANESTHESI OLOGY	0. 000000	27, 082		0	0	53. 00		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 285		0	0	54. 00		
58. 00	05800 MRI	0. 000000	0		0	0	58. 00		
60.00	06000 LABORATORY	0. 000000	3, 719		0	0	60.00		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	62. 00		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30		
65.00	06500 RESPI RATORY THERAPY	0. 000000	0		0	0	65. 00		
66. 00	06600 PHYSI CAL THERAPY	0. 000000	4, 579		0	0	66. 00		
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	21, 424		0	0	71. 00		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	342, 782		0	0	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	41, 613		0	0	73. 00		
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97		
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98		
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99		
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00		
92 00	00200 OPSEDVATION PEDS (NON DISTINCT DADT	0.000000	0			1	02.00		

0. 000000

669, 756

0 90.00 0 92.00 0 200.00

0 0 0

0 0 0

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

Health Financial Systems	ORTHOPAEDI C HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0167	Peri od:	Worksheet D

From 01/01/2018 Part V To 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm Title XIX Hospi tal PPS Costs Charges Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 088815 284, 264 0 50.00 53.00 05300 ANESTHESI OLOGY 0.074369 20, 053 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.031669 0 3, 233 54.00 0 0.179678 0 58.00 05800 MRI 19, 963 0 58.00 60.00 06000 LABORATORY 0. 243996 1,008 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 62.00 O 0. 000000 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.606283 1, 012 0 65.00 06600 PHYSI CAL THERAPY 0. 338830 66.00 0 0 66.00 06900 ELECTROCARDI OLOGY 69.00 0.008289 69 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 216833 28, 007 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 235466 110, 337 0 72.00 07300 DRUGS CHARGED TO PATIENTS 21, 668 73.00 0.136198 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0.000000 0 0 Ω 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 167007 555 0 92.00 200.00 Subtotal (see instructions) 490, 100 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 0 202. 00 202.00 0 490, 100

Health Financial Systems	ORTHOPAEDI C HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepared: 5/28/2019 3:49 pm

				To 12/31/2018	Date/Time Pre 5/28/2019 3:4	
	_	Ti tl	e XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	25, 247	0				50.00
53. 00 05300 ANESTHESI OLOGY	1, 491	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	102	0				54.00
58. 00 05800 MRI	3, 587	0				58.00
60. 00 06000 LABORATORY	246	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0				62. 30
65. 00 06500 RESPI RATORY THERAPY	614	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	O	0				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 073	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 981	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 951	0				73. 00
76. 97 O7697 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 T		ı			
90. 00 09000 CLINIC	0	0				90. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	648	0				92. 00
200.00 Subtotal (see instructions)	66, 940	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges (Line 200 Line 201)	44 040	0				202 00
202.00 Net Charges (line 200 - line 201)	66, 940	0	I			202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0167	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/28/2019 3:4	
	Title XVIII	Hospi tal	PPS	
Cost Contan Decemintion				

		Title XVIII	Hospi tal	5/28/2019 3: 4 PPS	<i>y</i> piii	
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			6, 093	1. 00 2. 00	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-t Private room days (excluding swing-bed and observation bed day		vate room days	6, 093 0	3.00	
0.00	do not complete this line.	, , , , , , , , , , , , , , , , , , ,	Tato Toom dayo,	· ·	0.00	
4.00	Semi-private room days (excluding swing-bed and observation be			5, 407	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 OF the COST	0	5. 00	
6.00						
7.00	reporting period (if calendar year, enter 0 on this line)					
7.00	7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period					
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 754	9. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10.00	
44.00	through December 31 of the cost reporting period (see instruct					
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11. 00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
	through December 31 of the cost reporting period			_		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00	Total nursery days (title V or XIX only)			0	15. 00	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				16. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00	
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00	
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instructions	.)		6, 734, 470	21. 00	
21.00	Swing-bed cost applicable to SNF type services through Decembe		na period (line	0, 734, 470	22.00	
	5 x line 17)	•				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 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 (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 734, 470	27. 00	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30. 00 31. 00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	111le 20)		0.00000	32.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00		
35. 00 36. 00	Average per diem private room cost differential (line 34 x lir Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	6, 734, 470	37.00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	STMENTS				
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 105. 28	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line			1, 938, 661		
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39	+ IIne 40)	l	1, 938, 661	41.00	

Provider CRL 15-016	Heal th	Financial Systems 0	RTHOPAEDI C HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
Cost Center Description						Peri od:	Worksheet D-1	
Total Tota							Date/Time Pre	
Inpati ent Cost Inpati ent Dosplate in Cost 1		Cost Center Description	Total				PPS	
1.00		oust defited bescription			Diem (col. 1		(col. 3 x col.	
Interest use Care Type Inpartient Hospital Units			1.00	2.00		4. 00		
	42. 00	, ,,,						42. 00
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61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Allowable Inpatient (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Michael Inpatient cost plus incentive payment (see instructions) 64.00 Michael Inpatient Routline SWING BED COST 65.00 Michael Inpatient Routline SWING BED COST 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) For CAH (see instructions) (title VXIII only) For CAH (see instructions) For CAH (see instructions) (title VXIII only) For CAH (see instructions) For CAH	60.00		cost report ur	dated by the m	narket hasket		0.00	60.00
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75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 75.00 Total Program inpatient routine service costs (from Worksheet B, Part II, column 75.00 Total Program and III are per vice of the part		Medically necessary private room cost applicable to Program (line 14 x line 35)						73. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 77.00 78.00 77.00 78.00 78.00 79.00 81.00 81.00 81.00 82.00 83.00 84.00 85.00 86.00		Capital-related cost allocated to inpatient				Part II, column		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		Per diem capital-related costs (line 75 ÷ li	,					76.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00								78.00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Reasonable inpatient routine service costs (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Reasonable inpatient routine service costs (see instructions) 85.00 Reasonable inpatient routine service costs (see instructions) 86.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service (see instructions) 87.00 Reasonable in		Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 83.00 84.00 84.00 84.00 85.00 85.00 86.00 87.00 87.00								80.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		On Impatient routine service cost limitation (line 9 x line 81)						
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		· · · · · · · · · · · · · · · · · · ·		13)				83.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,105.28 88.00		Utilization review - physician compensation	(see instructio					85. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,105.28 88.00	oo. UU	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ii ougii 85)				00.00
				line 2)				1
				/				1

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	690, 232	6, 734, 470	0. 10249	2 758, 222	77, 712	90.00
91.00 Nursing School cost	0	6, 734, 470	0.00000	0 758, 222	0	91.00
92.00 Allied health cost	0	6, 734, 470	0.00000	0 758, 222	0	92.00
93.00 All other Medical Education	0	6, 734, 470	0. 00000	0 758, 222	0	93. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prep 5/28/2019 3:4	
	Title XIX	Hospi tal	PPS	<i>y</i> p
Cost Center Description			1 00	

			12,01,2010	5/28/2019 3: 49	9 pm		
	Title XIX Hospital						
	Cost Center Description						
				1. 00			
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days			6, 093	1. 00		
2.00	Inpatient days (including private room days, excluding swing-			6, 093	2. 00		
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00		
4 00	do not complete this line.			F 407	4 00		
4.00	Semi-private room days (excluding swing-bed and observation be		04 0 11	5, 407	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00		
	reporting period		04 6 11	ا	, 00		
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00		
7 00	reporting period (if calendar year, enter 0 on this line)	n daya) thraugh Dagambar	21 of the cost	o	7 00		
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	ii days) through beceiiber	31 Of the Cost	١	7. 00		
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	o	8. 00		
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	1 of the cost	١	0.00		
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-had and	62	9. 00		
7.00	newborn days)	The frogram (excruding	Swifig-bed and	1	7.00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	0	10. 00		
	through December 31 of the cost reporting period (see instructions)		oom dayo)	ĭ			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, er			,			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	ol	12.00		
	through December 31 of the cost reporting period	3 (3 1	,				
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00		
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00		
15. 00	Total nursery days (title V or XIX only)			0	15.00		
16.00	Nursery days (title V or XIX only)			0	16.00		
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17.00		
	reporting period						
18. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	18. 00				
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00		
00.00	reporting period	CL D L 01 C L			00.00		
20. 00	Medical drate for swing-bed NF services applicable to services	s arter becember 31 or t	ne cost	0.00	20. 00		
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		6, 734, 470	21 00		
22. 00	Swing-bed cost applicable to SNF type services through December		ing ported (line	0, 734, 470	22. 00		
22.00	5 x line 17)	er 31 or the cost report	ing perrou (inne	١	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	o	23. 00		
23.00	x line 18)	or the cost reportin	g perrod (Trile o	١	23.00		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00		
21100	7 x line 19)	or or the east report.	ing pointed (initial	١	21.00		
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00		
	x line 20)	, ,	` `				
26.00	Total swing-bed cost (see instructions)			0	26.00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 734, 470	27.00		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)			0			
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00		
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000			
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00					
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00					
34. 00	Average per diem private room charge differential (line 32 mir	0.00					
35. 00	Average per diem private room cost differential (line 34 x line 35)	0.00					
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	irerential (IIne	6, 734, 470	37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
		ISTMENTS					
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1 105 20	38. 00		
38. 00 39. 00	Program general inpatient routine service cost per diem (see			1, 105. 28 68, 527			
40. 00	Medically necessary private room cost applicable to the Progra	•		00, 527	40.00		
	Total Program general inpatient routine service cost (line 39	,		68, 527			
11.00	1.04 Sgram general impatreme routine service cost (Time 37		ı	00, 027	11.00		

Heal th	Financial Systems 0	RTHOPAEDI C HOSI	PT. AT PARKVI	EW	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Т:	+Lo VIV	Hospi tal	5/28/2019 3:4	9 pm
	Cost Center Description	Total Inpatient Cost	Total	Average Per ays Diem (col. 1	Program Days	PPS Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)			3.33		0.00	42. 00
	Intensive Care Type Inpatient Hospital Units	1				1	
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Drogram i posti est appillant comitae cost (Wk	a+ D 2 aal 2	line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			tions)		115, 555 184, 082	1
50. 00	Pass through costs applicable to Program inp	atient routine	services (fr	rom Wkst. D, su	m of Parts I and	7, 023	50.00
51. 00	Pass through costs applicable to Program inpand IV)		ry services ((from Wkst. D,	sum of Parts II	4, 511	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-p	ohysician anest	hetist, and	11, 534 172, 548	1
	medical education costs (line 49 minus line	52)					1
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	irget amount	(line 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996,	updated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	e market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				,	0	61. 00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54	x 60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +l	21 -6			1 0	(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of 1	the cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	e cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	e 65)(title XVI	II only). For	0	66. 00
67. 00]	e costs through	December 3	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [ecember 31 d	of the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c	-			,		71.00
72. 00	Program routine service cost (line 9 x line						72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	•					77. 00
78. 00	Inpatient routine service cost (line 74 minu	•					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces				nus line 70)		79. 00 80. 00
81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iiiii tati	on (TIME 70 IIII	1103 1116 /7)		81.00
82. 00	Inpatient routine service cost limitation ()				82. 00
83. 00	Reasonable inpatient routine service costs (ıs)				83. 00
84.00	Program inpatient ancillary services (see in		une)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugii (J)				1 33.00
87. 00	Total observation bed days (see instructions)				686	•
88. 00	Adjusted general inpatient routine cost per					1, 105. 28	1
07.00	Observation bed cost (line 87 x line 88) (se	e mstructions)				758, 222	09.00

Health Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	690, 232	6, 734, 470	0. 10249	2 758, 222	77, 712	90. 00
91.00 Nursing School cost	0	6, 734, 470	0.00000	0 758, 222	0	91.00
92.00 Allied health cost	0	6, 734, 470	0.00000	0 758, 222	0	92.00
93.00 All other Medical Education	0	6, 734, 470	0. 00000	0 758, 222	0	93. 00

Heal th	Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW		In Li€	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0167	Peri od:	Worksheet D-3	
				From 01/01/2018 To 12/31/2018		nared·
				10 12/01/2010	5/28/2019 3:4	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4.00	0.00	2)	
	I NDATI ENT DOUTING CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	2 04/ 575		30.00
30.00	ANCILLARY SERVICE COST CENTERS			2, 846, 575		30.00
50.00	05000 OPERATING ROOM		0. 0888	5 30, 622, 751	2, 719, 760	50.00
53. 00	05300 ANESTHESI OLOGY		0.0000			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 03166	, ,		
58. 00	05800 MRI		0. 17967			
60. 00	06000 LABORATORY		0. 24399	.,		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		0	1
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62. 30
65.00	06500 RESPIRATORY THERAPY		0. 60628	33 20, 612	12, 497	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 33883	1, 222, 354	414, 170	66. 00
69.00	06900 ELECTROCARDI OLOGY		0. 00828	34, 203		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21683			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 23546			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 13619	.,		
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 00000		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0. 00000		0	76. 98
76. 99	07699 LI THOTRI PSY		0.00000	00 0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20		00.00
90.00	09000 CLINIC		0.00000			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	d 0/ th: 00)	1. 16700		0	, 2. 00
200. 00 201. 00	1 1 1			72, 220, 523	11, 617, 603	200.00
201.00				72, 220, 523		201.00
202.00)	I	12, 220, 323	I	1202.00

Health Financial Systems ORTHOPAEDIC HOSP	T. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 3:4	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Inpatient Program	Inpatient Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.011		00.00
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS			10, 841		30. 00
50, 00 05000 OPERATING ROOM		0. 08881	5 224, 272	19, 919	50.00
53. 00 05300 ANESTHESI OLOGY		0.00001			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 03166			
58. 00 05800 MRI		0. 17967		0	58. 00
60. 00 06000 LABORATORY		0. 24399		907	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	0 0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 60628		0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 33883		1, 552	
69. 00 06900 ELECTROCARDI OLOGY		0. 00828		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 21683			1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 23546			1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 13619			1
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY		0. 00000 0. 00000		0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	76.99
90. 00 09000 CLI NI C		0.00000	ol o	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 16700		o o	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 10700	669, 756		
201.00 Less PBP Clinic Laboratory Services-Program only charce	es (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)	,	1	669, 756	l .	202. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/28/2019 3:49 pm

		Title XVIII	Hospi tal	5/28/2019 3: 4 ³ PPS	9 pm
	·			1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prinstructions)	orior to October 1 (s	see	8, 635, 933	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring of	2, 737, 747	1. 02		
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for di 1 (see instructions)</pre>	scharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for di October 1 (see instructions)	scharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions)			30, 718 0	2. 00 2. 01
2. 01	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions))		0	2. 01
3.00	Managed Care Simulated Payments			9, 736, 639	3. 00
4.00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	y period (see instruc	ctions)	35. 12	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most record before 12/31/1996. (see instructions)	cent cost reporting p	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the conew programs in accordance with 42 CFR 413.79(e)	riteria for an add-or	n to the cap for	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 (cost report straddles July 1, 2011 then see instructions.	.FR §412.105(T)(1)(1\	/)(B)(2) IT the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots upon the traddiction with 1 2011 and instructions.	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots in the property of the prope	from a closed teachin	ng hospital	0.00	8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	3, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the current y</pre>	year from your record	ls	0.00	10. 00
	FTE count for residents in dental and podiatric programs.				11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year en	nded on or after Sept	ember 30, 1997,	0. 00	
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital closure				17. 00
	Adjusted rolling average FTE count				18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
20.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
	IME payment adjustment (see instructions)			0.000000	22. 00
	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.	cap slots under 42 CF	FR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower instructions)	of line 23 or line	24 (see	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	1			0.000000	
28. 00	IME add-on adjustment amount (see instructions)			0	28.00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
	Percentage of SSI recipient patient days to Medicare Part A patien	nt days (see instruct	i ons)	0.00	
31. 00	, , , , , , , , , , , , , , , , , , , ,			0.00	
32. 00	Sum of lines 30 and 31			0.00	
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			0.00	
34. UU	יין אין סיף אין טוומנפ אומו פי מען עש נווופודנ (שפי דוושנו עכנו טווש)		ı	υį	34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre 5/28/2019 3:4	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompanyated Care Adjustment		1.00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent	er zero on this line) (se		0	1
	instructions)				
35. 03	Pro rata share of the hospital uncompensated care payment am		0	0	
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35. Additional payment for high percentage of ESRD beneficiary d		ab 46)		36.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	,			
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00
44 04	instructions)	DD0 /50 /00 /00 /00			44 04
41. 01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	o-DRGS 652, 682, 683, 684	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43. 00
	instructions)				
44. 00	Ratio of average length of stay to one week (line 43 divided	I by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ne)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4	•	0.00		46.00
47. 00	Subtotal (see instructions)		11, 404, 398		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
49. 00	Total payment for inpatient operating costs (see instruction	ne)		1. 00 11, 404, 398	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	•		913, 953	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	1
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52. 00
53.00	Nursing and Allied Health Managed Care payment			0	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
56. 00	Cost of physicians' services in a teaching hospital (see int	•		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt.	•	hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)			12, 318, 351	
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	us line 60)		0 12, 318, 351	60.00
62. 00	Deductibles billed to program beneficiaries	is title 00)		1, 146, 042	
63.00	Coinsurance billed to program beneficiaries				63. 00
64.00	Allowable bad debts (see instructions)			19, 985	64.00
65. 00	Adjusted reimbursable bad debts (see instructions)			12, 990	65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS DDCs (s	oo instructions)	11, 185, 299	1
68. 00 69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)		,	0	1
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (. 3. 33. 33. 1113.1 40.11011	~ <i>,</i>	0	
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration	1		0	
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	structions)		2	70.89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	ı
70. 91	Bundled Model 1 discount amount (see instructions)			0	1
70. 93	HVBP payment adjustment amount (see instructions)			0	1
	HVBP payment adjustment amount (see instructions)				
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			0	70. 94

Health Financial Systems	ORTHOPAEDI C HOSPT. A	T PARKVIEW		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CC	N: 15-0167		Worksheet E Part A Date/Time Pre 5/28/2019 3:4	
		Title	XVIII	Hospi tal	PPS	<u> </u>
			FFY	(уууу)	Amount	
				0	1. 00	
70.06 Low volume adjustment for federal fiscal	year (year) (Enter in	col ump 0		0	0	70.06

			Ė	o 12/31/2018		
		Title	xVIII	Hospi tal	5/28/2019 3: 4 ⁻ PPS	9 piii
		11 11 0		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 97
, 0. , ,	the corresponding federal year for the period ending on or aft				Ü	' ' ' ' '
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	69 & 70)			11, 185, 299	
71. 01	Sequestration adjustment (see instructions)				223, 706	1
71. 02	Demonstration payment adjustment amount after sequestration				10.040.063	•
72. 00 73. 00	Interim payments Tentative settlement (for contractor use only)				10, 948, 863	72. 00 73. 00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			12, 730	•
7 11 00	73)	-, , , , , aa			.2, 700	7 00
75. 00	Protested amounts (nonallowable cost report items) in accordar	nce with			0	75. 00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instru				0	
93.00	Capital outlier reconciliation adjustment amount (see instruct	,			0	
94. 00 95. 00	The rate used to calculate the time value of money (see instru Time value of money for operating expenses (see instructions)	ictions)			0.00	•
96.00	Time value of money for capital related expenses (see instructions)	ions)			0	1
70.00	Trine varies or money for substant related expenses (see first det	. 1 0113)		Prior to 10/1		70.00
				1. 00	2. 00	
400.00	HSP Bonus Payment Amount			1 0		1400 00
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100. 00
101 00	HVBP adjustment factor (see instructions)			0.0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instructions	(;)		0.000000000		102.00
	HRR Adjustment for HSP Bonus Payment	,		-1		
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	<u> </u>		0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr					
200.00	Is this the first year of the current 5-year demonstration per	riod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
201 00	Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	, 10)				201. 00
	Medicare discharges (see instructions)	7 47)				202.00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5-year demonst	rati on	
	peri od)					
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
207 00	Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
	Adjustment to Medicare IPPS payments (see instructions)	- ,				209. 00
	Reserved for future use					210. 00
211.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
	Comparision of PPS versus Cost Reimbursement					
	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost roim	bursomont)			213. 00 218. 00
Z 10. UC	(line 212 minus line 213) (see instructions)	ia cost reliii	ibui seiletti)			2 10.00
	1					

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0167	From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/28/2019 3:49 pm

			10 12/31/2018	5/28/2019 3:4	
		Title XVIII	Hospi tal	PPS	<i>7</i> piii
			•		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		0 3, 785, 835	
	OPPS payments	ti ons)		3, 509, 751	3.0
	Outlier payment (see instructions)			12, 615	l .
	Outlier reconciliation amount (see instructions)			0	l .
	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	1
	Line 2 times line 5			0	6.0
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
	Transitional corridor payment (see instructions)			0	
	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.0
	Reasonable charges				1
	Ancillary service charges			0	12. 0
1	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	ı
	Total reasonable charges (sum of lines 12 and 13)	·		0	14.0
	Customary charges				
	Aggregate amount actually collected from patients liable for p			0	
	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 0
1	had such payment been made in accordance with 42 CFR §413.13(6 Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 0
	Total customary charges (see instructions)			0.00000	1
	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	Ö	ı
	instructions)	,	, (
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	ne 18) (see	0	20. 0
	instructions)			_	
1	Lesser of cost or charges (see instructions)			0	
1	Interns and residents (see instructions)	rueti enc)		0	22. 0 23. 0
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		3, 522, 366	ı
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			3, 322, 300	27.0
	Deductibles and coinsurance amounts (for CAH, see instructions	s)		623, 616	25.0
26. 00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr	uctions)	0	26. 0
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) μ	plus the sum of lines 22	and 23] (see	2, 898, 750	27. 0
	instructions)				00.0
	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	The 50)		0	28.0
	Subtotal (sum of lines 27 through 29)			2, 898, 750	1
1	Primary payer payments			0	31.0
1	Subtotal (line 30 minus line 31)			2, 898, 750	32.0
Ţ	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
1	Composite rate ESRD (from Wkst. I-5, line 11)			0	
1	Allowable bad debts (see instructions)			53, 011	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		34, 457 46, 455	
	Subtotal (see instructions)	ructions)		2, 933, 207	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 5
	Demonstration payment adjustment amount before sequestration			0	1
1	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			2, 933, 207	40.0
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			58, 664	
1	Interim payments			2, 840, 772	1
1	Tentative settlement (for contractors use only)			2,010,772	1
1	Balance due provider/program (see instructions)			33, 771	1
	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2		·		
	TO BE COMPLETED BY CONTRACTOR				
					90.0
90. 00	Original outlier amount (see instructions)			0	
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.0
90. 00 91. 00 92. 00	Original outlier amount (see instructions)			_	91. 0 92. 0

Health Financial Systems ORTHOP
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/28/2019 3: 49 pm Provider CCN: 15-0167

					5/28/2019 3: 49) pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		10, 948, 86	3	2, 840, 772	1. 00
2.00	Interim payments payable on individual bills, either			ol	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			<u>'</u>		
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02				o	0	3. 02
3. 03				o	0	3. 03
3. 04				Ö	o	3. 04
3. 05				o o	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	7.BSGSTIMENTO TO TROOM III			o o	l ol	3. 51
3. 52				0	0	3. 52
3. 53				o	l ő	3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 948, 86	3	2, 840, 772	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		10, 710, 00		2,010,772	1. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider				•	
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02				Ö	o	5. 02
5. 03				Ö	o	5. 03
	Provider to Program			-1		
5.50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51				o	o	5. 51
5. 52				ō	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			ō	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		12, 73	ol	33, 771	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		10, 961, 59	-	2, 874, 543	7. 00
	, (333 mot 434 313)		, , , 0 ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	'			•	. '	

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	. AT PARKVIEW	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0167	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II	epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	I	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		I	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			I	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		I	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			I	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		I	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			I	8. 00
9.00	Sequestration adjustment amount (see instructions)			I	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		I	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	•			
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)			I	31. 00
22 00	Delenes due provider (line 0 (en line 10) minus line 20 and l	ing 21) (and instruction)	ı	22.00

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

30. 00 31. 00 32. 00

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

Provi der CCN: 15-0167

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm

——————————————————————————————————————					5/28/2019 3:4	9 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	14, 369, 962		0	0	1.00
2.00	Temporary investments	0	d	0	l	2. 00
3.00	Notes receivable	0	o c	0	0	3. 00
4.00	Accounts receivable	24, 670, 733	C	0	0	4. 00
5.00	Other recei vable	0	C	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	O C	0	0	6. 00
7. 00	Inventory	0	C	0	0	7. 00
8.00	Prepai d expenses	-2, 411, 663	1	0	0	8. 00
9.00	Other current assets	0	0	_	0	9.00
10.00	Due from other funds	27 720 022	0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	36, 629, 032	<u> </u> C	0	0	11. 00
12. 00	Land	1	C	0	0	12. 00
13. 00	Land improvements					13.00
14. 00	Accumulated depreciation	0	i c	_		14. 00
15. 00	Bui I di ngs	9, 446, 043	d	0	Ō	15. 00
16.00	Accumul ated depreciation	-3, 010, 063	1	0	0	16. 00
17.00	Leasehold improvements	6, 304, 390	o c	0	0	17. 00
18. 00	Accumul ated depreciation	-2, 931, 207	C	0	0	18. 00
19. 00	Fi xed equipment	157, 301	0	0	0	19. 00
20. 00	Accumulated depreciation	-91, 530	1	0	0	20. 00
21. 00	Automobiles and trucks	21, 045	1	0	0	21. 00
22. 00	Accumul ated depreciation	-17, 977	1	0	0	22. 00
23. 00	Major movable equipment	22, 004, 045	l .	0	0	23. 00
24. 00	Accumulated depreciation	-15, 305, 639	i	_	0	24. 00
25. 00	Minor equipment depreciable Accumulated depreciation	0	C	_	0	25. 00 26. 00
26. 00 27. 00	HIT designated Assets	0		0		27.00
28. 00	Accumulated depreciation	0		0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0		0		29.00
30. 00	Total fixed assets (sum of lines 12-29)	16, 576, 408	-	_		30.00
	OTHER ASSETS					
31.00	Investments	0	C	0	0	31.00
32.00	Deposits on Leases	0	C	0		32. 00
33. 00	Due from owners/officers	0	C	0	0	33. 00
34.00	Other assets	59, 357, 051	1		0	34. 00
35. 00	Total other assets (sum of lines 31-34)	59, 357, 051	0	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	112, 562, 491	C	0	0	36. 00
27.00	CURRENT LI ABI LI TI ES	12 (10 001	1	0		1 27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	12, 619, 981	0	_	1	37. 00 38. 00
39. 00	Payroll taxes payable	0		_		39.00
40. 00	Notes and Loans payable (short term)	0		_	0	40.00
41. 00	Deferred income	0		0	0	41.00
42. 00	Accel erated payments	0	Ĭ	J	Ĭ	42. 00
43. 00	Due to other funds	o o		0	0	43. 00
44.00	Other current liabilities	2, 140, 039	d	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14, 760, 020	o c	0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	C	0		46. 00
47.00	Notes payable	0	1			47. 00
48. 00	Unsecured Loans	0	C		1	48. 00
49. 00	Other long term liabilities	1, 996, 668		_	1	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 996, 668	l .			50.00
51. 00	Total liabilities (sum of lines 45 and 50)	16, 756, 688	C	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	95, 805, 803	1			E2 00
52. 00 53. 00	Specific purpose fund	95, 605, 605				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant	1			0	57.00
58. 00	Plant fund balance - reserve for plant improvement,		1		ő	58. 00
	replacement, and expansion					
59. 00	Total fund balances (sum of lines 52 thru 58)	95, 805, 803	C	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	112, 562, 491	C	0	0	60. 00
	[59]	1	l			l

In Lieu of Form CMS-2552-10 Health Financial Systems ORTHOPAEDI C HOSPT. AT PARKVI EW STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0167 Peri od: Worksheet G-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 3:49 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 351, 541, 085 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 89, 963, 512 2.00 Total (sum of line 1 and line 2) 3.00 441, 504, 597 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 441, 504, 597 11.00 11.00 0 DEDUCTIONS TRANSFERS 346, 800, 000 12.00 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 346, 800, 000 18.00 18.00 Fund balance at end of period per balance 19.00 94, 704, 597 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 DEDUCTIONS TRANSFERS 12.00 13.00 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

19.00

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Health Financial Systems ORT STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0167

			10 12/31/2018	5/28/2019 3:4	
	Cost Center Description	I npati ent	Outpati ent	Total	7 PIII
	3337 331131 33331 pt 311	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	8, 261, 8	58	8, 261, 868	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 261, 8	58	8, 261, 868	10. 00
	Intensive Care Type Inpatient Hospital Services		1		
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	0.241.0	. 0	8, 261, 868	17. 00
18. 00	Ancillary services	8, 261, 8d 245, 123, 00		404, 992, 248	
19. 00	Outpatient services	245, 123, 00	0 139, 809, 240	404, 992, 240	19. 00
20. 00	RURAL HEALTH CLINIC		0 0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		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 99, 094, 253	99, 094, 253	
26. 00	HOSPI CE		11, 11, 11	, ,	26. 00
27. 00	PARKVIEW PHYSICAL THERAPY REVENUE		0 18, 170, 672	18, 170, 672	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	st. 253, 384, 8	76 277, 134, 165	530, 519, 041	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		95, 657, 310		29. 00
30.00	HOME OFFICE INTEREST EXPENSE	1, 101, 20)6		30.00
31. 00			0		31. 00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		1, 101, 206		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39.00			0		39. 00
40. 00 41. 00			0		40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)		٥		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nsfer	96, 758, 516		42.00
43.00	to Wkst. G-3, line 4)	1131 61	70, 730, 310		43.00
	1 to mot. 6 6, 11116 7)	1	1		

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVIFW	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0167	Peri od:	Worksheet G-3	1002 10
01711211	ENT OF NEVEROLO 7885 ENTEROLO	11.01.00.	From 01/01/2018		
			To 12/31/2018		
				5/28/2019 3:4	9 pm
				1 00	
1 00	Total matient manages (from What C 2 Point I and man 2 line	- 20)		1. 00	1. 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			530, 519, 041	
2.00	Less contractual allowances and discounts on patients' accounts and discounts on patients' accounts.	TS		344, 463, 993	2.00
3.00	Net patient revenues (line 1 minus line 2)	42)		186, 055, 048	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		96, 758, 516	4.00
5.00	Net income from service to patients (line 3 minus line 4)			89, 296, 532	5. 00
	OTHER INCOME			210 017	6. 00
6.00	Contributions, donations, bequests, etc			218, 816	
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	Servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13. 00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patrents		7, 515	
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
	OTHER OPERATING REVENUE			478, 249	
25 00	Total ather income (our of lines (24)			704 500	1 25 00

37, 600 27. 00 37, 600 28. 00 89, 963, 512 29. 00

25.00 26.00

704, 580 90, 001, 112

25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)

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

27. 00 GAIN ON SALE OF ASSET

PART 1 - FULLY PROSPECTIVE METHOD 1.00	CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0167	Peri od: From 01/01/2018	Worksheet L Parts I-III	
PART I - FULLY PROSPECTIVE METHOD				To 12/31/2018		
PART 1 - FULLY PROSPECTIVE METHOD			Title XVIII	Hospi tal		, piii
PART 1 - FULLY PROSPECTIVE METHOD						
Capital DRG other than outlier 913.953 1.		DART I FILLY PROCEEDING METHOD			1. 00	
200 Capital DRG other than outlier 913,993 1.						
101 Model 4 BPCI Capital DRG other than outlier 0 0 1.	1 00				012 053	1.00
0.00 Agin	1. 01					
101 Nodel 4 BPCI Capital DRG outlier payments 15.09 2.3 15.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 15.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	2. 00	·			- 1	
Number of interns & residents (see instructions) 0.00 4.	2. 01					
Indirect medical education percentage (see instructions) 0.00 5.	3.00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	tructions)	15. 09	3.00
Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, see instructions) Sum of lines 1 and 1.01, see instructions) One percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) One percentage of Medical dipatient days to total days (see instructions) One 1.00 One 1.0	4.00	Number of interns & residents (see instructions)		·	0. 00	4.00
. 1.01)(see instructions) Observentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient days to total days (see instructions) Observentage of Medicaid patient (see instructions) Observentage of Medicaid patien	5.00				0.00	5.00
30) (see instructions) 0 Percentage of Medicaid patient days to total days (see instructions) 0 Percentage of Medicaid patient days to total days (see instructions) 0 Union Disproportionate share adjustment (see instructions) 0 Union Disproportionate share adjustment (see instructions) 10 Union Disproportionate share adjustment (see instructions) 11 Union Disproportionate share adjustment (see instructions) 12 Union Disproportionate share adjustment (see instructions) 13 Union Disproportionate share adjustment (see instructions) 14 Union Disproportionate share adjustment (see instructions) 15 Union Disproportionate share	6. 00	, , , , , ,	e sum of lines 1 and 1.0°	I, columns 1 and	0	6. 00
Sum of lines 7 and 8 0.00 9.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 0.00 1.00 0.00	7. 00	30) (see instructions)	,	E, part A line		
Allowable disproportionate share percentage (see instructions) 0.00 10.	8. 00		uctions)			
Disproportionate share adjustment (see instructions) 0 11.	9.00		`			
2.00 Total prospective capital payments (see instructions) PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) O Total inpatient program capital cost (line 1 plus line 2) D Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) O Adjustment to capital minimum payment level (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) O Adjustment to capital minimum payment level (ror extraordinary circumstances (line 2 x line 6) Capital minimum payment (line 5 plus line 7) O Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 1.00 Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) 1.00 Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) O Current year exception payment level to capital payments (line 10 plus line 11) O Current year exception payment level to capital payments (line 10 plus line 11) O Current year allowable operating and capital payment (see instructions)		, , , , , , , , , , , , , , , , , , , ,	5)			
PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) Program inpatient anciliary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Percentage adjustment for extraordinary circumstances (see instructions) Percentage adjustment for extraordinary circumstances (see instructions) Capital cost for comparison to payments (line 3 x line 4) Capital minimum payment level (line 5 plus line 7) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) Current year comparison of capital minimum payment level to capital payments (line 10 plus line 11) Carryover of accumulated capital minimum payment level to capital payments (line 10 plus line 11) Current year exception payment (if line 12 is positive, enter the amount on this line) Current year allowable operating and capital payment (see instructions) Olicurrent year allowable operating and capital payment (see instructions) Olicurent year allowable operating and capital payment (see instructions) Olicurent year allowable operating and capital enter the amount on this line) Olicurent year allowable operating and capital payment (see instructions)						
PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) 0 Program inpatient ancillary capital cost (see instructions) 0 Total inpatient program capital cost (line 1 plus line 2) 0 Capital cost payment factor (see instructions) 0 Total inpatient program capital cost (line 3 x line 4) 0 Total inpatient program capital cost (line 3 x line 4) 0 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) 0 Program inpatient capital costs (fine 1 minus line 2) 0 Applicable exception percentage (see instructions) 0 Applicable exception percentage (see instructions) 0 Capital cost for comparison to payments (line 3 x line 4) 0 Percentage adjustment for extraordinary circumstances (see instructions) 0 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 Adjustment to capital minimum payment level for extraordinary circumstances (line 8 less line 9) 0 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 0 Current year comparison of capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 0 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) 0 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 0 Current year allowable operating and capital payment (see instructions) 0 15. 0 Current year allowable operating and capital payment (see instructions)	12.00	Total prospective capital payments (see Histructions)			913, 933	12.00
Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions) Of total inpatient program capital cost (line 1 plus line 2) Of total inpatient program capital cost (line 3 x line 4) Of total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Of Program inpatient capital costs (see instructions) Of Program inpatient capital costs (line 1 minus line 2) Of Applicable exception percentage (see instructions) Of Capital cost for comparison to payments (line 3 x line 4) Of Capital cost for comparison to payments (line 3 x line 4) Of Capital cost for comparison to payments (line 3 x line 4) Of Capital minimum payment level for extraordinary circumstances (line 2 x line 6) Of Capital minimum payment level (line 5 plus line 7) Of Capital minimum payment level (line 5 plus line 7) Of Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Of Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L. Part III. line 14) Of Current year exception payment (line 12 is negative, enter the amount on this line) Of Current year exception payment (line 12 is negative, enter the amount on this line) Of Current year operating and capital payment (see instructions) Of Current year operating and capital payment (see instructions) Of Current year operating and capital payment (see instructions) Of Current year operating and capital payment (see instructions) Of the comparison of capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) Of Current year operating and capital payment (see instructions)					1. 00	
Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2) Total inpatient program capital cost (line 1 plus line 2) Total inpatient program capital cost (line 3 x line 4) Dotal inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) Current year comparison of capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14) Locurrent year exception payment (if line 12 is positive, enter the amount on this line) Current year exception payment (if line 12 is positive, enter the amount on this line) Current year operating and capital minimum payment (see instructions) 0 15. 0 15. 0 16. 0 16. 0 17.						
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