This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0167 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/28/2024 8: 51 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 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 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Jeanne Wickens		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jeanne Wickens			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
PART I	II - SETTLEMENT SUMMARY						
1.00 H0SPI	TAL		0 -159, 170	34, 194	0	0	1. 00
2.00 SUBPRO	OVIDER - IPF		0 0	0		0	2. 00
3.00 SUBPRO	OVIDER - IRF		0 0	0		0	3. 00
5. 00 SWI NG	BED - SNF		0 0	0		0	5. 00
6. 00 SWI NG	BED - NF		o			0	6. 00
200. 00 TOTAL			0 -159, 170	34, 194	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

use only

Health Financial Systems ORTHOPAEDI C HOSPT. AT PARKVI EW In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0167 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 8:51 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 11130 PARKVIEW CIRCLE 1.00 PO Box: 1.00 State: IN Zip Code: 46845-1735 County: ALLEN 2.00 City: FORT WAYNE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ORTHOPAEDIC HOSPT. AT 150167 23060 1 11/08/2007 N 3.00 PARKVI FW Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

Enter the number of FTE residents that your hospital trained in this cost reporting period for which

1.00

0.00 62.00

62.00

Health Financial Systems	ORTHOPAFD	DIC HOSPT.AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COM				eriod: com 01/01/2023	Worksheet S-2 Part I	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Ye						
period that begins on or after 64.00 Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to 1 settings. Enter in column 2 th resident FTEs that trained in 1 of (column 1 divided by (column	s yes, or your facilit mber of unweighted nor otations occurring in de number of unweighted your hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nannnavi dan	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1.00	2.00	3. 00	4. 00	5.00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00 Unwei ghted	0.00 Unweighted FTEs in	0.000000 Ratio (col. 1/ (col. 1 + col.	65. 00
			Nonprovi der Si te 1.00	Hospi tal	3.00	
Section 5504 of the ACA Curren		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-primar occurring in all nonpr unweighted non-primar tal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67.00

116. 00

117. 00

118. 00

Ν

"N" for no.

the definition in CMS Pub. 15-1, chapter 22, §2208.1.

116.00 Is this facility classified as a referral center? Enter "Y" for yes or

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

ealth Financial Systems ORTHOPAEDIC HOSPT.	Provider CC	CN: 15-0167	Period: From 01/01	/2023 /2023	w of Form (Worksheet Part I Date/Time 5/28/2024 Insurance	S-2 Prepared: 8:51 am
		1. 00	2.0		3.00	
18.01 List amounts of malpractice premiums and paid losses:		237, 2	29	0		0 118. 0
			1. 00	0	2.00	110.0
18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N			118. 0
19.00 DO NOT USE THIS LINE 20.00 Is 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 qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y' Hifies for th	' for yes or ne Outpatient			N	119. 0 120. 0
21.00 Did this facility incur and report costs for high cost implan	itable devices	s charged to	Y			121. 0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi 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.						122. 0
23.00 Did the facility and/or its subproviders (if applicable) purc services, e.g., legal, accounting, tax preparation, bookkeepi	ng, payroll,	and/or	Y		Y	123. 0
management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from u located in a CBSA outside of the main hospital CBSA? In column "N" for no.	greater than Inrelated orga	50% of total anizations				
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant ce		'Y" for yes	N			125. 0
and "N" for no. If yes, enter certification date(s) (mm/dd/yy 26.00 f this is a Medicare-certified kidney transplant program, en		fication dat	:e			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, ent in column 1 and termination date, if applicable, in column 2.						127. 0
28.00 If this is a Medicare-certified liver transplant program, ent in column 1 and termination date, if applicable, in column 2.						128. 0
29.00 If this is a Medicare-certified lung transplant program, ente in column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare-certified pancreas transplant program,						129. C
date in column 1 and termination date, if applicable, in column 31.00 f this is a Medicare-certified intestinal transplant program	ımn 2.		1			131. 0
date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare-certified islet transplant program, ent in column 1 and termination date, if applicable, in column 2.	er the certif	fication date				132. 0
 33.00 Removed and reserved 34.00 If this is a hospital-based organ procurement organization (0 in column 1 and termination date, if applicable, in column 2. 	PO), enter th	ne OPO number	-			133. 0 134. 0
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y are claimed, enter in column 2 the home office chain number.	es, and home	office costs	, Y		15H032	140. 0
1.00 2.00 If this facility is part of a chain organization, enter on li	nes 1/1 thro	ugh 143 the r		.00	of the	
home office and enter the home office contractor name and con	ntractor numbe	er.				
41.00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISC SERV		I ANS Contract	or's Number	r: 0810	11	141. 0
42.00 Street: 1450 PRODUCTION ROAD PO Box: 43.00 City: FORT WAYNE State: IN		Zi p Code	:	4680	81167	142. 0 143. 0
44 00 Arg provider based physicians' costs included in Wartsheet A3	· · · · · · · · · · · · · · · · · · ·				1.00 N	144 6
44.00 Are provider based physicians' costs included in Worksheet A?						144. C
45.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in c	olumn 1. If o	column 1 is	1.00	0	2.00	145. 0
no, does the dialysis facility include Medicare utilization f period? Enter "Y" for yes or "N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15	ly filed cost	t report?	N			146. C

Health Financial Systems			AT PARKVIEW			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	N: 15-0167	Peri Fror To	od: n 01/01/2023 12/31/2023		epared:
							1. 00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for ye	s or "N" for	no.			N N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	od? Ent	er "Y" for ye	s or "N" f	or no.		N	149. 00
			Part A	Part B		Title V	Title XIX	
			1.00	2.00		3.00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal	N TOT NO TOT Each Co	olliporieri	N N	and Part E	s. (See	N 42 CFR 9413	. 13) N	155. 00
156. 00 Subprovi der – TPF			N	N	1	N	N	156. 00
157. 00 Subprovi der - I RF			N N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1. 00	
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more campu	ses in dif	ferent	CBSAs?	N	165. 00
	Name		County		Zip Co		FTE/Campus	
	0		1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0. 0	166. 00
							1. 00	-
Health Information Technology (HI	Γ) incentive in the Ar	meri can	Recovery and	Reinvestm	nent Ac	ct	1.00	
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a me	eani ngf	ul user (line	167 is "Y	"), en	iter the		168. 00
reasonable cost incurred for the H								
168.01 If this provider is a CAH and is r						ardshi p		168. 01
exception under §413.70(a)(6)(ii)′ 169.00 If this provider is a meaningful u	user (line 167 is "Y")					, enter the	9. 9	99169. 00
transition factor. (see instruction	ons)					Begi nni ng	Endi ng	
						1. 00	2. 00	+
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and end	ding da	te for the re	porting		1.00	2.00	170. 00
perrod respectively (min/dd/yyyy)						1. 00	2.00	
171.00 f line 167 is "Y", does this prov	/ider have any days fo	or indi	viduals enrol	led in		N N	2.00	0 171. 00
section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I	, line 2, col	. 6? Enter				171.30

Heal th	Financial Systems ORTHOPAEDIC HOSF	PT. AT PARKVLEW		In Li€	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		epared:
				Y/N	5/28/2024 8:5	51 am
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE					
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					+
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	orumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare P		N			2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	ın 3, "V" Tor				
3.00	Is the provider involved in business transactions, including	g management	N			3.00
	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					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			1.00	2. 00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	
4.00	Column 1: Were the financial statements prepared by a Cert		Y	A	04/18/2024	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	iiiabie in				
5.00	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
	those on the filed financial statements? If yes, submit rec	onciliation.				
				1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provide	r N		6. 00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	etructions		N		7. 00
8.00	Were nursing programs and/or allied health programs approve		ed during the			8.00
	cost reporting period? If yes, see instructions.		J			
9. 00	Are costs claimed for Interns and Residents in an approved	•	al education	N		9. 00
10.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
40.00	Bad Debts	· · · · · · · · · · · · · · · · · · ·			T	10.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			nst reporting	Y N	12. 00 13. 00
13.00	period? If yes, submit copy.	orrey change c	idi i iig tiii 3 Ci	ost reporting	l N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsura	ince amounts wa	nived? If yes	, see	N	14. 00
	instructions. Bed Complement					-
15. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	N	15. 00
			t A		t B	
		Y/N 1.00	2.00	Y/N 3. 00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	05/23/2024	Υ	05/24/2024	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
17.00	Report data for corrections of other PS&R Report			14		' 00
	information? If yes, see instructions.		[

Heal th	Financial Systems ORTHOPAEDIC HOS	PT. AT PARKVIEW	1	In Lie	u of Form CMS-	2552-10
HOSPI 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/28/2024 8:5	epared:
			i pti on	Y/N	Y/N	
20.00	16 1: 1/ 17 :		0	1. 00	3.00	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Troport data for other bookings the other day actiones.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)		1.00	
	Capital Related Cost		ĺ			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ng the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entered	ea into during	this cost re	porting period?		24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rtina neriod?	If ves see		25. 00
20.00	instructions.	the cost repo	i ting periou?	11 yes, see		25.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ina period? I	f ves. see		26. 00
	instructions.		5 1	J ,		
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit	N	27. 00
	copy.					1
20.00	Interest Expense	-4			N.	1 20 00
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	nterea into au	ring the cost	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	eserve Fund)	N	29. 00
27.00	treated as a funded depreciation account? If yes, see instr		001 11 00 11	333. 13 . 44)		27.00
30.00	Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	N	30.00
	instructions.					
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	see	N	31.00
	instructions.					-
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual	N	32. 00
32.00	arrangements with suppliers of services? If yes, see instru		ca tili oagii co	iti de tuai	14	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33.00
	no, see instructions.	· ·				_
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	N	34.00
25 00	If yes, see instructions.	istina sansons	n+o wi+h +ho :	anavi dan basad		35. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	or ovi der -based		35.00
	phrysroruns during the cost roporting period. It yes, see it	noti de ti ono.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00	Were home office costs claimed on the cost report?			Y		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		37. 00
20 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	fica diffarant	from that of	NI		20 00
30. UU	the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other			N		39.00
	see instructions.		, , , , , , , , , , , , , , , , , , ,			
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	i nstructi ons.					
		1	00		00	
	Cost Report Preparer Contact Information		. 00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	SHANNON		ECENBARGER		41.00
11.00	held by the cost report preparer in columns 1, 2, and 3,	J. 17 WWW.		LOLIND, MOLIK		55
	respectivel y.					
42.00	Enter the employer/company name of the cost report	PARKVI EW HEAL		42.00		
	preparer.					
43. 00	·	2604377558		SHANNON. ECENBA	RGER@PARKVI EW.	43.00
	report preparer in columns 1 and 2, respectively.	1		COM		II

Heal th I	Financial Systems	ORTHOPAEDIC HOSP	T. AT PAR	KVI EW			In Lie	u of Form Cl	/S-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi	der CCN: 1	5-0167	Peri		Worksheet	S-2	
						From	n 01/01/2023 12/31/2023		Dror	arod:
						10	12/31/2023	5/28/2024	8։ 51	am
				3.00						
	Cost Report Preparer Contact Information									
	Enter the first name, last name and the ti		OI RECTOR,	REI MBURS	EMENT					41.00
	held by the cost report preparer in column:	s 1, 2, and 3,								
	respecti vel y.									
42. 00 I	Enter the employer/company name of the cos	t report								42.00
	preparer.									
	Enter the telephone number and email addres									43.00
[1	report preparer in columns 1 and 2, respec	ti vel y.								

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

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
						I/P Days / 0/P	ı aiii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Compensite	Li ne No.	110. 01 2000	Avai I abl e		'''''	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	11.00	2.00	0.00		0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		37 13,	505 0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and			,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation			37 13,	505 0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)			37 13,	505 0.00	0	14. 00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16.00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)			37			27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)			o	0		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0	0	34.00
		٠. '		*	•	•	

Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0167

Perio	oa:	worksneet	5-3				
From	01/01/2023	Part I					
To	12/31/2023	Date/Time	Pre	pared:			
		5/28/2024	8: 5	1 am			
Full Time Familiants							

				1	0 12/31/2023	5/28/2024 8:5	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	278	6	1, 160			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)	547	76				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	270	0	1 1/0			6.00
7. 00	Total Adults and Peds. (exclude observation	278	6	1, 160			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	278	6	1, 160	0.00	191. 40	1
15. 00	CAH visits	0	0	1, 100	0.00	171.10	15. 00
15. 10	REH hours and visits	o	o	0			15. 10
16. 00	SUBPROVI DER - I PF	-	آ	_			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	23. 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		0.00	
27. 00	Total (sum of lines 14-26)				0. 00	191. 40	
28. 00	Observation Bed Days		0	50			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			0			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
33. 00	outpatient days (see instructions)	0					33.00
	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0		0			1
34.00	Tremporary expansion covid-19 Pric Acute Care	ı V	0	U		1	34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | Part | P Health Financial Systems ORTHOPAED
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0167

				10	0 12/31/2023	Date/IIMe Prep 5/28/2024 8:5	
		Full Time		Di sch	arges	07 207 202 1 0. 0	i diii
		Equi val ents		5. 55.	u. 900		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	155	3	600	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)			267	35		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						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)	0. 00	0	155	3	600	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	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 Tri ps						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
22 00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days	}		0			33. 00 33. 01
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	}		١			34. 00
54.00	Transportary Expansion Covid-19 The Acute Care	ı			'		34.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0167

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From CMS-2552-10 | Part II | Pa

					''	o 12/31/2023	Date/lime Pre 5/28/2024 8:5	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3. 00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
1. 00	SALARI ES	200. 00	21 202 772	14 020 270	25 221 041	005 000 00	20.07	1.00
2. 00	Total salaries (see instructions) Non-physician anesthetist Part	200.00	21, 292, 662	14, 029, 279 0				
3. 00	A Non-physician anesthetist Part		0	0		0.00		
4. 00	B Physician-Part A -		0	0	0			
4. 01	Administrative Physicians - Part A - Teaching		0	0	0			
5. 00	Physician and Non Physician-Part B		0	0	ō	0. 00		
6.00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	10, 413, 003	10, 413, 003	253, 749. 00	41. 04	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 4, 701, 557	0 1, 299, 723	0 6, 001, 280	0. 00 236, 101. 00		
10.00	instructions) OTHER WAGES & RELATED COSTS		1, 701, 307	1,277,720	0, 001, 200	200, 101. 00	20. 12	10.00
11. 00	Contract Labor: Direct Patient Care		0	0	0	0.00	0. 00	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		0	0	0	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0	10, 413, 003	10, 413, 003	253, 749. 00	41. 04	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0. 00	
16. 00	- Administrative Home office and Contract		0	0	0	0. 00		
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0.00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		10, 972, 181	0	10, 972, 181			17. 00
18.00	Wage-related costs (other) (see instructions)		0.044.500		0.047.500			18.00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 216, 522 0	0	2, 216, 522 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		4, 469, 555	0	4, 469, 555			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							

Provider CCN: 15-0167

					To	o 12/31/2023		
							5/28/2024 8: 5	<u>1 am</u>
		Wkst. A Line		Recl assi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
	1	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII				_			
26. 00	Employee Benefits Department	4. 00	412, 872					
27. 00	Administrative & General	5. 00	1, 146, 855	10, 244, 855	11, 391, 710	·		
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	0. 00		29. 00
30. 00	Operation of Plant	7. 00	0	152, 152	152, 152	·	1	
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32. 00	Housekeepi ng	9. 00	448, 851	70, 660	519, 511	22, 127. 00	1	
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	88, 707	149, 598	238, 305	·		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	0. 00		36.00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00	1	
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	724.00	41. 06	39.00
40.00	Pharmacy	15. 00	0	1, 188	1, 188	29. 00	40. 97	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	223, 520	3, 155	226, 675	4, 912. 00	46. 15	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

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

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0167 Worksheet S-3 Peri od: From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/28/2024 8:51 am 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 . Salaries in col . 5) (from 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 21, 292, 662 24, 908, 938 632, 139. 00 1.00 3, 616, 276 39. 40 instructions) 2.00 4, 701, 557 1, 299, 723 6, 001, 280 236, 101. 00 25. 42 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 16, 591, 105 2, 316, 553 18, 907, 658 396, 038. 00 47.74 3.00 minus line 2) 4.00 Subtotal other wages & related 0 10, 413, 003 10, 413, 003 253, 749. 00 41.04 4.00

12, 729, 556

10, 238, 463

15, 441, 736

44, 762, 397

12, 559, 268

0.00

649, 787. 00

298, 633. 00

81.67

68 89

42.06

5.00

6.00

7.00

15, 441, 736

32, 032, 841

2, 320, 805

costs (see inst.)

(see inst.)

instructions)

5.00

6.00

7.00

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

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	From 01/01/2023	Worksheet S-3 Part IV Date/Time Prepared:

	10 12/31/20	23 Date/lime Prep 5/28/2024 8:5	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	734, 724	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2, 278, 767	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	6, 560	6. 00
7.00	Employee Managed Care Program Administration Fees	121, 743	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)	5, 320, 578	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 492, 046	9. 00
10.00	Dental, Hearing and Vision Plan	183, 375	
11. 00	Life Insurance (If employee is owner or beneficiary)	34, 936	
12.00	1	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	128, 318	
14. 00		0	14. 00
15. 00		20, 118	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
	FICA-Employers Portion Only	2, 762, 763	
	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
04 00	OTHER	04 500	04 00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (so	ee 21, 580	21. 00
22.00	instructions)) Day Care Cost and Allowances	0	22. 00
22. 00	Tuition Reimbursement	83, 195	
∠4. UU	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	13, 188, 703	24. 00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	JUHIEN WAGE NELATED 00313 (SPECIFT)	1	25.00

Health Financial Systems ORTHOPAEDI	C HOSPT. AT PARKVIEW	. AT PARKVIEW In Li		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prepared: 5/28/2024 8:51 am	

		10 12/31/2023	5/28/2024 8:5					
	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	13, 188, 703	1.00				
2.00	Hospi tal	0	13, 188, 703	2.00				
3.00	SUBPROVI DER - I PF			3.00				
4.00	SUBPROVI DER - I RF			4. 00				
5.00	Subprovi der - (0ther)	0	0	5. 00				
6.00	Swing Beds - SNF	0	0	6. 00				
7.00	Swing Beds - NF	0	0	7. 00				
8.00	SKILLED NURSING FACILITY			8. 00				
9.00	NURSING FACILITY			9. 00				
10.00	OTHER LONG TERM CARE I			10.00				
11. 00	Hospi tal -Based HHA			11.00				
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	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 DIALYSIS I			17.00				
18. 00	Other	0	0	18. 00				

	Financial Systems	ORTHOPAEDI C HOSPT. F				eu of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023		pared:
	DART I HOORITAL AND HOORITAL COURTY) A T A				1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX I Uncompensated and Indigent Care Cost-to-						1
	Cost to charge ratio (see instructions)	Charge Ratio				0. 190646	1.00
	Medicaid (see instructions for each line	2)				0. 190040	1.00
2. 00							
3.00	Did you receive DSH or supplemental pays	ments from Medicaid?				1, 314, 233	3. 00
	If line 3 is yes, does line 2 include al		tal navments	s from Medica	ai d?		4. 00
5. 00	If line 4 is no, then enter DSH and/or s				ar a .	0	1
	Medi cai d charges	зарргешента разшенте г	. o modi odi i	.		17, 213, 843	
	Medicaid cost (line 1 times line 6)					3, 281, 750	
	Difference between net revenue and costs	s for Medicaid program	(see instru	ctions)		1, 967, 497	
	Children's Health Insurance Program (CHI						1
9.00	Net revenue from stand-alone CHIP					0	9. 00
10.00	Stand-alone CHIP charges				0	10.00	
	Stand-alone CHIP cost (line 1 times line					0	
	Difference between net revenue and costs					0	12. 00
	Other state or local government indigent						
	Net revenue from state or local indigen					9, 635, 708	
	Charges for patients covered under state 10)	Ü		Not included	in lines 6 or	52, 689, 971	
	State or local indigent care program cos					10, 045, 132	1
	Difference between net revenue and costs					409, 424	16. 00
	Grants, donations and total unreimbursed instructions for each line)	·			gent care program		
	Private grants, donations, or endowment					0	
	Government grants, appropriations or tra					0	
19. 00	Total unreimbursed cost for Medicaid , (8, 12 and 16)	CHIP and state and loca	l indigent o	care programs	s (sum of lines	2, 376, 921	19. 00
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col. 2)	
				1.00	2. 00	3. 00	
	Uncompensated care cost (see instruction		<u> </u>	F40.04	27 (47 470	4.4(0.007	
	Charity care charges and uninsured disco			512, 83			
21. 00	Cost of patients approved for charity calinstructions)	are and uninsured disco	unts (see	97, 7	70 526, 850	624, 620	21. 00
22. 00	Payments received from patients for amou	ints previously written	off as		0 0	0	22. 00
22.00	charity care	anto providuory written	011 03		9	ĺ	22.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

149, 032

68, 430

105, 276

348, 891

973, 511

3, 350, 432 31. 00

1, 742, 053

1, 636, 777

24.00

25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25. 01

27. 00

27.01

28. 00

stay limit

	Financial Systems	ORTHOPAEDI C HOSPT. AT				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	P	Provider CCM		Period: From 01/01/2023 To 12/31/2023		pared:
						4.00	
	PART II - HOSPITAL DATA					1. 00	
	Uncompensated and Indigent Care Cost-to-Ch	narge Ratio					1
	Cost to charge ratio (see instructions)	iai ge nati e				0. 186591	1.00
	Medicaid (see instructions for each line)					0. 100071	1.00
2.00	Net revenue from Medicaid						2.00
3. 00						3.00	
	If line 3 is yes, does line 2 include all		al pavments	from Medica	i d?		4. 00
5.00	If line 4 is no, then enter DSH and/or sup						5.00
6.00	Medi cai d charges						6.00
7.00	Medicaid cost (line 1 times line 6)						7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions) 8.00						
	Children's Health Insurance Program (CHIP)	(see instructions for	r each line)			
9.00							9.00
	Stand-alone CHIP charges						10.00
	Stand-alone CHIP cost (line 1 times line 1						11. 00
	Difference between net revenue and costs f						12. 00
	Other state or local government indigent of						
	Net revenue from state or local indigent of						13.00
14. 00	Charges for patients covered under state of 10)	or local indigent care	program (N	ot included	in lines 6 or		14. 00
15.00	State or local indigent care program cost	(line 1 times line 14))				15.00
	Difference between net revenue and costs f						16. 00
	Grants, donations and total unreimbursed c instructions for each line)	cost for Medicaid, CHIF	P and state	/local indig	ent care program	ns (see	
17.00	Private grants, donations, or endowment in	ncome restricted to fur	nding chari	ty care			17. 00
18.00	Government grants, appropriations or trans	sfers for support of ho	ospital ope	rati ons			18.00
19. 00	Total unreimbursed cost for Medicaid , CHI 8, 12 and 16)	P and state and local	indigent c	are programs	(sum of lines		19. 00
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col . 2)	
				1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions						
	Charity care charges and uninsured discour			512, 83			
21. 00	Cost of patients approved for charity care instructions)	e and uninsured discour	nts (see	95, 69	1 526, 246	621, 937	21.00
22. 00	Payments received from patients for amount	ts previously written o	off as		0 0	0	22. 00
00	charity care		25				50
23. 00	Cost of charity care (see instructions)			95. 69	1 526, 246	621, 937	1 22 00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

149, 032

68, 430

105, 276

342, 254

964, 191

964, 191 31. 00

1, 742, 053

1, 636, 777

24.00

25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25. 01

27. 00

27.01

28.00

stay limit

Heal th	Financial Systems (ORTHOPAEDIC HOSPT.AT PARKVIEW In Lieu			eu of Form CMS-2	2552-10	
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/28/2024 8:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		i diii
	occi conten becomparen	00.0.100	0 21.101	+ col . 2)	ons (See A-6)	Trial Balance	
				'	,	(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 692, 264	2, 692, 264	-1, 028, 954	1, 663, 310	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	C	1, 028, 954	1, 028, 954	2. 00
3.00	00300 OTHER CAP REL COSTS		0	l c	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	412, 872	5, 496, 396	5, 909, 268	-412, 872	5, 496, 396	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 146, 855	22, 835, 015	23, 981, 870	329, 753	24, 311, 623	5. 00
7.00	00700 OPERATION OF PLANT	0	495, 723	495, 723	-7	495, 716	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	C	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	448, 851	192, 771	641, 622	6, 336	647, 958	9. 00
10.00	01000 DI ETARY	88, 707	148, 346	237, 053	1, 252	238, 305	10.00
11. 00	01100 CAFETERI A	0	0	C	0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	C	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	0	0	C	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	29, 727	29, 727	0	29, 727	14. 00
15. 00	01500 PHARMACY	0	1, 188	1, 188	0	1, 188	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	223, 520	96, 507	320, 027	3, 155	323, 182	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	C	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	C	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 412, 432	573, 251	3, 985, 683	-92, 437	3, 893, 246	30. 00
	ANCILLARY SERVICE COST CENTERS	0.454.400	54 540 700		44 440 070	10.000.100	
50.00	05000 OPERATING ROOM	9, 154, 622	51, 542, 780				1
53. 00	05300 ANESTHESI OLOGY	0	0	1	_, _, _, _,	2, 395, 011	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	474 404	64, 703			64, 703	1
58. 00	05800 MRI	474, 496	256, 217			737, 135	1
60.00	06000 LABORATORY	0	502, 861	502, 861	0	502, 861	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	
62. 30 65. 00	06500 RESPIRATORY THERAPY	0	0		0		
66. 00	06600 PHYSI CAL THERAPY	1, 134, 094	44, 567	1, 178, 661	16, 010		66.00
69. 00	06900 ELECTROCARDI OLOGY	1, 134, 094	44, 307	1, 170, 001	16,010	1, 194, 6/1	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		4, 471, 627	4, 471, 627	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	Ö			1
73. 00	07300 DRUGS CHARGED TO PATIENTS	94, 656	1, 902, 271			1	
76. 97	07697 CARDI AC REHABILITATION	74, 030	1, 702, 271	1, 770, 727	1, 330	1, 770, 203	1
76. 77	07698 HYPERBARI C OXYGEN THERAPY		0		0	Ö	1
76. 79	07699 LI THOTRI PSY		0		0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0	l o	0	Ö	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0		0	0	
70.00	OUTPATIENT SERVICE COST CENTERS	3					70.00
90.00	09000 CLI NI C	0	0	C	0	0	90.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			Ī			92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>					
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	4, 701, 557	9, 992, 859	14, 694, 416	-980, 745	13, 713, 671	115. 00
118.00		21, 292, 662	96, 867, 446				
	NONREI MBURSABLE COST CENTERS						
194.00	07951 PHYS THERAPY PERFORMANCE CENTER	0	783	783	0		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	21, 292, 662	96, 868, 229	118, 160, 891	0	118, 160, 891	200. 00

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	ORTHOPAEDIC HOSE	PT. AT PARKVIEW Provider CCN: 15-016	In Lieu of Form Cl 7 Period: Worksheet	
11202/11		0. 2.11 2.11020		From 01/01/2023 To 12/31/2023 Date/Time	Prepared:
	Cost Center Description	Adjustments	Net Expenses	5/28/2024	8:51 am
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	1, 663, 310		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 028, 954		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 496, 396		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	10, 241, 394	34, 553, 017		5.00
7.00	00700 OPERATION OF PLANT	0	495, 716		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	l		8.00
9.00	00900 HOUSEKEEPI NG	0	647, 958		9. 00
10.00	01000 DI ETARY	0	238, 305		10.00
11. 00	01100 CAFETERI A	0	0		11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	o o		12. 00
13. 00		0	_		13.00
	1	0			
14.00		0	29, 727		14. 00
	01500 PHARMACY	0	1, 188		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
17. 00	1	0	323, 182		17. 00
19. 00	1	0	0		19. 00
	02000 NURSI NG PROGRAM	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	0		22. 00
23.00	02300 PARAMED ED PRGM	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	68, 058	3, 961, 304		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	19, 233, 429		50.00
53.00	05300 ANESTHESI OLOGY	0	2, 395, 011		53.00
54.00	1	0	64, 703		54.00
58. 00	05800 MRI	0	737, 135		58.00
60. 00	06000 LABORATORY	0	502, 861		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			62. 30
65. 00		0			65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 194, 671		66. 00
	06900 ELECTROCARDI OLOGY	0	1, 194, 071		69. 00
71.00		0	4 471 427		71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	35, 719, 132		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
76. 97		0	0		76. 97
76. 98		0	0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0	0		90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS				
115. 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	1, 245, 846	14, 959, 517		115. 00
118.00		11, 555, 298			118. 00
2. 5.	NONREI MBURSABLE COST CENTERS	, , , , , , , , , ,			
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	161	944		194. 00
200.00		11, 555, 459	1		200. 00
_55.50	1.5.7.2 (55 5. 2.1125 115 till bagil 177)	1, 555, 757	1 .27,7.07,500		1200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0167

					1	0 12/31/202	5/28/2024 8:51 am
		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		•	<u>1, 028, 9</u> 54			1. 0
	0		0	1, 028, 954			
4 00	B - MED AND IV SUPPLIES	74 00		00 010 011			
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	39, 210, 014			1. 0
2. 00	PATI ENT	0.00	o	o			2.0
3. 00		0.00	o	0			3. 0
3.00				<u>39, 210, 014</u>			3. 0
	C - TELEPHONE EXPENSE		<u> </u>	37, 210, 014			
1. 00	ADMI NI STRATI VE & GENERAL	5.00	O	7			1. (
2. 00	TOWN WE OF SERVICE	0.00	ő				2. 0
2.00			- — —	<u>0</u>			2. 0
	D - PTO PAID		<u> </u>	,			
1.00	ADMINISTRATIVE & GENERAL	5.00	16, 190	0			1. (
2. 00	HOUSEKEEPI NG	9. 00	6, 336	Ö			2. 0
3.00	SOCI AL SERVI CE	17. 00	3, 155	Ö			3. 0
4.00	ADULTS & PEDIATRICS	30.00	46, 375	O			4. 0
5.00	OPERATING ROOM	50.00	129, 232	Ō			5. 0
6.00	MRI	58.00	6, 698	0			6.0
7.00	PHYSI CAL THERAPY	66.00	16, 010	0			7.0
8.00	DRUGS CHARGED TO PATIENTS	73. 00	1, 336	0			8. 0
9.00	DI ETARY	10.00	<u>1, 2</u> 52	0			9. 0
	0		226, 584	0			
	F - HOME OFFICE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	9, 113, 280	0			1.0
2.00	AMBULATORY SURGICAL CENTER	115. 00	1, 299, 654	0			2.0
	(D. P.)						
3.00	PHYS THERAPY PERFORMANCE	194. 00	69	0			3.0
	CENTER	+	10, 413, 003	— — _ō			
	H - PURCHASED SERVICES		10, 413, 003	U			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	801, 829	0			1. (
2. 00	OPERATION OF PLANT	7. 00	152, 152	0			2.0
3. 00	HOUSEKEEPI NG	9. 00	64, 324	o			3. 0
4. 00	DI ETARY	10.00	148, 346	ő			4. 0
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	29, 727	Ö			5. 0
6. 00	PHARMACY	15. 00	1, 188	Ö			6. 0
7. 00	ADULTS & PEDIATRICS	30.00	737	Ö			7. 0
8.00	OPERATING ROOM	50.00	1, 139, 964	0			8.0
9.00	RADI OLOGY-DI AGNOSTI C	54.00	64, 696	0			9. 0
10.00	LABORATORY	60.00	486, 220	0			10.0
11.00	PHYSI CAL THERAPY	66.00	23, 089	0			11. 0
12.00	DRUGS CHARGED TO PATIENTS	73.00	704, 004	0			12. 0
	0		3, 616, 276	0			
	I - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO	72. 00	0	35, 719, 132			1. 0
	PATI ENTS	,		_			
2.00		0.00	0	0			2.0
	U ANECTHECIA		0	35, 719, 132			
1 00	J - ANESTHESIA	F2 00		2 205 011			
1. 00	ANESTHESI OLOGY	<u>53.</u> 00	0	<u>2, 395, 011</u>			1.0
	K - ORPOC LEASED EMPLOYEE BEN	IEEI TO	U	2, 395, 011			
1. 00	AMBULATORY SURGICAL CENTER	115.00	٥	0			1. (
1.00	(D. P.)	115.00	٩	U			1.0
	Po., — — — — —	+	- — — 	₀			
	L - BONUS DOLLARS RECLASS		٥	٥			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	313, 556	0			1. (
2.00		0. 00	0	ő			2. 0
		— — +	313, 556	— — <u>ö</u>			2.0
500.00	Grand Total: Increases		14, 569, 419	78, 353, 118			500. 0
							1

Provider CCN: 15-0167

| Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/28/2024 8:51 am

						5/28/2024 8: !	5 <u>1 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - BUILDING DEPRECIATON						
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	<u>1, 028, 9</u> 54	9		1.00
	0		0	1, 028, 954]
	B - MED AND IV SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	11, 544	0		1.00
2.00	OPERATING ROOM	50.00	0	39, 198, 194	0		2. 00
3.00	MRI	58. 00	0	276	0		3. 00
	0		0	39, 210, 014			
	C - TELEPHONE EXPENSE						
1.00	OPERATING ROOM	50.00	0	0	0		1. 00
2.00	OPERATION OF PLANT	7.00	0	7	0		2. 00
				_			
	D - PTO PAID						1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	226, 584	0	0		1.00
2.00		0.00	O	0	0		2. 00
3.00		0.00	o	0	0		3. 00
4.00		0.00	o	0	O		4. 00
5.00		0.00	o	0	o		5. 00
6.00		0.00	ol	0	o		6. 00
7.00		0.00	o	0	0		7. 00
8.00		0.00	0	0	0		8. 00
9. 00		0.00	ō	0	0		9. 00
7.00			226, 584	0			7.00
	F - HOME OFFICE		220, 001				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9, 113, 280	0		1. 00
2. 00	AMBULATORY SURGICAL CENTER	115. 00	Ö	1, 299, 654	0		2. 00
2.00	(D. P.)	113.00	٩	1, 2,77, 034			2.00
3.00	PHYS THERAPY PERFORMANCE	194. 00	0	69	0		3. 00
0.00	CENTER	171.00	٩	0,			0.00
	0	+		10, 413, 003			
	H - PURCHASED SERVICES		<u> </u>	10, 413, 003			1
1.00	ADMINISTRATIVE & GENERAL	5.00	O	801, 829	0		1. 00
2. 00	OPERATION OF PLANT	7. 00	o	152, 152	0		2. 00
3.00	HOUSEKEEPI NG	9.00	ő	64, 324	0		3. 00
4.00	DI ETARY	10. 00	o	148, 346	0		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	29, 727	0		5. 00
6.00	PHARMACY	15. 00	0	1, 188	0		6. 00
7. 00	ADULTS & PEDIATRICS	30.00	0	737	0		7. 00
8.00	OPERATING ROOM	50.00	0		0		8. 00
			0	1, 139, 964	0		
9.00	RADI OLOGY-DI AGNOSTI C	54.00	U O	64, 696	U		9. 00
10.00	LABORATORY	60.00	0	486, 220	0		10.00
11. 00	PHYSI CAL THERAPY	66.00	0	23, 089	0		11.00
12. 00	DRUGS CHARGED TO PATIENTS	73.00	0	704, 004			12. 00
	0		0	3, 616, 276			-
4 00	I - IMPLANTS	74 00		04 700 007			1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	34, 738, 387	0		1. 00
	PATI ENT	445.00		000 745			
2.00	AMBULATORY SURGICAL CENTER	115. 00	0	980, 745	0		2. 00
	(D. P.)	+					
	0		0	35, 719, 132			1
	J - ANESTHESIA						1
1. 00	OPERATING ROOM	5000	•	<u>2, 395, 011</u>			1. 00
	0		0	2, 395, 011]
	K - ORPOC LEASED EMPLOYEE BEN						
1.00	AMBULATORY SURGICAL CENTER	115.00	0	0	0		1. 00
	(D. P.)						
	0		0	0]
	L - BONUS DOLLARS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	186, 288	0	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	127, 268	0	0		2. 00
			313, 556		1		
500.00	Grand Total: Decreases		540, 140	92, 382, 397			500.00
		'		•	'		

10.00 Total (line 8 minus line 9)

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0167 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and 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 2.00 Land Improvements 0 2.00 3, 091, 785 0 3, 091, 785 3.00 12, 707, 426 3.00 Buildings and Fixtures 361, 100 11, 338, 819 0 4.00 Building Improvements 439, 103 439, 103 0 4.00 5.00 Fixed Equipment 8, 920, 176 83, 900 0 83, 900 5.00 0 6.00 Movable Equipment 14, 887, 352 -64, 200 -64, 200 6.00 13, 656 0 7.00 HIT designated Assets 3, 731, 535 170, 175 170, 175 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 51, 585, 308 3, 720, 763 3, 720, 763 374, 756 8.00 9.00 Reconciling Items 0 9.00 51, 585, 308 374, 756 Total (line 8 minus line 9) 3, 720, 763 3, 720, 763 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 15, 438, 111 1, 989, 884 3.00 4.00 Building Improvements 11, 777, 922 3, 380, 399 4.00 5.00 Fi xed Equipment 9, 004, 076 44, 171 5.00 Movable Equipment 14, 809, 496 6.00 9, 385, 485 6.00 7.00 HIT designated Assets 3, 901, 710 7.00 Ω Subtotal (sum of lines 1-7) 8.00 54, 931, 315 14, 799, 939 8.00 9.00 Reconciling Items 9.00

54, 931, 315

14, 799, 939

Hoal th	Financial Systems	ORTHOPAEDIC HOSI	OT AT DADKVIEW		In lie	eu of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS	SKINOI ALBI C 11031	Provider Co	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	'I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 692, 264	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 692, 264	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 692, 264			ļ	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			l	2. 00
3 00	Total (sum of lines 1-2)	1	2 692 264	ĺ			3 00

0 0 0

2, 692, 264

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/28/2024 8:5	
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1. 00	2.00	2) 3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	36, 220, 109	0	36, 220, 10	9 0. 709786	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 809, 496	0	14, 809, 49	6 0. 290214	0	2.00
3.00	Total (sum of lines 1-2)	51, 029, 605		51, 029, 60			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS		1	0 1, 663, 310	0	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	0	0		0 1, 003, 310		2. 00
3.00	Total (sum of lines 1-2)	0	0		0 2, 692, 264		3. 00
0.00	Trotal (sam of trilles 12)		Sl	JMMARY OF CAPI		J	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11. 00	12.00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	1, 663, 310	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			o o	1, 028, 954	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	2, 692, 264	3. 00

Peri od: Workshee From 01/01/2023 Provider CCN: 15-0167

				T	o 12/31/2023	Date/Time Pre	
				Expense Classification on		5/28/2024 8: 5	ı am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1.00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
<i>(</i> 00	expenses (chapter 8)		0		0.00	0	4 00
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	U	6. 00
7.00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)		_			_	
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9.00	Parking Lot (chapter 21)	4.0.2	0		0. 00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	U			U	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	13, 160, 930			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		0		0.00	0	
15. 00	Rental of quarters to employee and others		0		0.00	U	
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17.00	patients				0.00		17.00
17. 00	Sale of drugs to other than patients		0		0.00	0	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	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
21.00	interest, finance or penalty		O		0.00	J	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of 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 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
55. 55	therapy costs in excess of	, , , ,		3031 Ganton Borotou	37.00		00.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		*** Cost Center Deleted ***	68. 00		31. 00
31.00	pathology costs in excess of	H-0-3	U	Cost center pereted	68.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest OTHER OPERATING REVENUE	В					33. 00
<u></u>	JOHILK OFERALLING REVENUE	D	-21, 907	ADMINISTRATIVE & GENERAL	5. 00	ı Ol	J 33. UU

Heal th	Financial Systems	Ol	RTHOPAEDIC HOSI	PT. AT PARKVIEW	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
			Expense Classification on Worksheet A				
				To/From Which the Amount is	to be Adjusted		
	0 1 0 1 5 11	D : (0 (0)		0 1 0 1	1 1 1 11	W . A 7 D C	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	_	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
36.00	NON ALLOWABLE LOBBY EXPENSE	A	-4, 422	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
36. 01	NON ALLOWABLE LOBBY EXPENSE	A	0	ADULTS & PEDIATRICS	30.00	0	36. 01
36. 02	NON ALLOWABLE LOBBY EXPENSE	A	-544	AMBULATORY SURGICAL CENTER	115. 00	0	36. 02
				(D. P.)			
37.00	TELEMETRY	A	0	ÀDULTS & PEDIATRICS	30.00	0	37. 00
38. 00	PHYSICIAN ADMINISTRATION	l A 1	68, 058	ADULTS & PEDIATRICS	30.00	l 0	38. 00
	ADD-BACK						
39. 00	l ·	A	-1, 646, 656	ADMINISTRATIVE & GENERAL	5. 00	l 0	39. 00
	I	1				1	

11, 555, 459

50.00

50.00 TOTAL (sum of lines 1 thru 49)

⁽Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

 boon postou to normanest m					
			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	5. 00	В	O. OO PARKVIEW HEALTH SYSTEM, INC	60.00	6. 00
7	7. 00	В	O. OO NORTHEAST ORTHOPAEDIC	40.00	7. 00
			HOSPITAL INVE		
8	3. 00		0.00	0.00	8. 00
ç	9. 00		0.00	0.00	9. 00
1	10.00		0.00	0.00	10.00
1	100.00	G. Other (financial or			100.00
_		non-financial) specify:			

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

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.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Syste	ems	C	ORTHOPAEDIC HOS	PT. AT PARK	VI EW	In Lie	u of Form CMS-	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOW	IE Provi d	er CCN: 15-0167	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2023 To 12/31/2023	Doto/Time De	ononod.
							To 12/31/2023	Date/Time Pro 5/28/2024 8:5	
	Net	Wkst. A-7 Ref.	·		<u>'</u>				
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED A	AS A RESULT OF	TRANSACTI O	NS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO:	STS:							
1.00	11, 914, 379	0							1.00
2.00	1, 246, 390	0							2.00
3.00	161	0							3.00
4.00	0	0							4.00
5.00	13, 160, 930								5. 00
* The	amounts on line	es 1-4 (and sub	oscripts as appr	opriate) are t	ransferred	in detail to Wor	ksheet 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.

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	
The Secretary by virtue of the auth	ority granted under section 1914(b)(1) of the Social Security Act, requires that you fi	urn

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

Heal th	Financial Systems (ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre	pared:
			OADLTAL DEL	ATED COCTO		5/28/2024 8: 5	1 am
			CAPITAL REL	_ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DEDU & TIXI	WVDLL LQUIT	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A			DEI /IICTIMEICT		
		col . 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 663, 310	1, 663, 310				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 028, 954		1, 028, 95			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 496, 396	0	(5, 496, 396		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	34, 553, 017	390, 485			36, 731, 225	
7.00	00700 OPERATION OF PLANT	495, 716	0	215, 11		734, 509	
8.00	00800 LAUNDRY & LINEN SERVICE	(47.050	0		0 0	0	
9.00	00900 HOUSEKEEPI NG	647, 958	0		80, 841	728, 799	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	238, 305	0	18:	3 37, 082	275, 570	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13. 00	01300 NURSING ADMINISTRATION	0	0		0	0	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	29, 727	0		4, 626	34, 353	
15. 00	01500 PHARMACY	1, 188	0		185	1, 373	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 100	0		0 0	0	1
17. 00	01700 SOCIAL SERVICE	323, 182	0		35, 273	358, 455	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	1
20.00	02000 NURSI NG PROGRAM	0	0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	(0 (C	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00	03000 ADULTS & PEDIATRICS	3, 961, 304	496, 415	19, 59	518, 532	4, 995, 849	30. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	10 222 420	715 104	/25 70	1 (22 040	22 107 202	F0 00
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	19, 233, 429	715, 104		9 1, 622, 040 0 0	22, 196, 282 2, 395, 011	
54. 00	05400 RADI OLOGY	2, 395, 011 64, 703	0		10, 067	2, 395, 011 74, 770	
58. 00	05800 MRI	737, 135	34, 657	6, 98		853, 656	
60.00	06000 LABORATORY	502, 861	34, 037	0, 70	74, 676	578, 521	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 73,000	0,00,021	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	l o	0		0	Ö	1
65. 00	06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 194, 671	26, 649		4 182, 559	1, 403, 883	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 471, 627	0		0 0	4, 471, 627	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	35, 719, 132	0		0 0	35, 719, 132	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 998, 263	0	22, 13	4 124, 487	2, 144, 884	
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	
	07699 LI THOTRI PSY	0	0		0	0	
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	
78.00	OUTPATIENT SERVICE COST CENTERS	J U	U	'	J 0	U	78.00
90 00	09000 CLINIC	0	0	Ι (0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		O	· ·		0	1
,2,00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						1
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	14, 959, 517	0		7 933, 842		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	129, 715, 406	1, 663, 310	1, 028, 95	4 5, 496, 385	129, 715, 395	118. 00
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	944	0		0 11		194. 00
200.00	, ,						200.00
201.00	1 1 9	100 74/ 858	0	1 000 05	0		201.00
202.00	TOTAL (sum lines 118 through 201)	129, 716, 350	1, 663, 310	1, 028, 95	5, 496, 396	129, 716, 350	1202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/28/2024 8:51 am	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0167

				'	0 12/01/2020	5/28/2024 8: 5	1 am
	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	36, 731, 225					5. 00
7. 00	00700 OPERATION OF PLANT	290, 148	1, 024, 657				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0				8. 00
9. 00	00900 HOUSEKEEPI NG	287, 892	0	Ö	1, 016, 691		9. 00
10.00	01000 DI ETARY	108, 856	0				10.00
11. 00	01100 CAFETERI A	0	0	1	_		11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	1		0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	_		0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	13, 570	0		_	1	14.00
15. 00	01500 PHARMACY	542	0		_		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	342	0		_		16.00
17. 00	01700 SOCIAL SERVICE	141 500	0	0	_	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	141, 598	0	0	_	0	19.00
			0	1	_	1	
20.00	02000 NURSI NG PROGRAM	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	_		22. 00
23. 00	02300 PARAMED ED PRGM	U	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	4 070 475	000 (07	1			
30. 00	03000 ADULTS & PEDI ATRI CS	1, 973, 475	399, 627	0	396, 520	306, 272	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	0.7/0.040	F7F /77	1 0	F74 004		F0 00
50.00	05000 OPERATING ROOM	8, 768, 042	575, 677			0	50.00
53. 00	05300 ANESTHESI OLOGY	946, 084	0	-			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 536	0		_	1	54.00
58. 00	05800 MRI	337, 214	27, 900		,		58.00
60.00	06000 LABORATORY	228, 529	0	-	_		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	-	_		62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	_	1	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	0	_		65. 00
66. 00	06600 PHYSI CAL THERAPY	554, 566	21, 453				66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	-	_		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 766, 396	0	-	_	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 109, 842	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	847, 279	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	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
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	6, 327, 279	0	0	0	0	115. 00
118.00		36, 730, 848	1, 024, 657	0	1, 016, 691	384, 426	118. 00
	NONREI MBURSABLE COST CENTERS						
	07951 PHYS THERAPY PERFORMANCE CENTER	377	0	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers		0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	36, 731, 225	1, 024, 657	0	1, 016, 691	384, 426	202. 00
		. '			•	•	•

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0167

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared:

In Lieu of Form CMS-2552-10

5/28/2024 8:51 am 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 78, 154 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 0 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 47, 923 14.00 15.00 01500 PHARMACY 00000 1, 915 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16,00 0 0 0 17.00 01700 SOCIAL SERVICE 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 02000 NURSI NG PROGRAM 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 0 C 0 0 0 22.00 02300 PARAMED ED PRGM 0 0 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 78, 154 0 0 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 0 0 50.00 0 53.00 05300 ANESTHESI OLOGY 0 0 Ω 0 53 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 58.00 05800 MRI 0 0 0 58.00 0 60.00 06000 LABORATORY 00000000000 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 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 0 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 47, 923 0 72.00 07300 DRUGS CHARGED TO PATIENTS Ω 0 1, 915 73 00 73 00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 0 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 0 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0 77 00 Ω 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC О 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) n 0 0 115, 00 SUBTOTALS (SUM OF LINES 1 through 117) 78, 154 0 47, 923 1, 915 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 194. 00 07951 PHYS THERAPY PERFORMANCE CENTER 0 194. 00 0 C 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 0 0 201.00 0 47, 923 TOTAL (sum lines 118 through 201) 78.154 1, 915 202. 00 202.00

Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0167

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/28/2024 8:51 am INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSI NG SERVI CES-SALAR Y & FRINGES RECORDS & ANESTHETI STS **PROGRAM APPRV** LI BRARY 19.00 20.00 16.00 17.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 500, 053 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19 00 02000 NURSING PROGRAM 20.00 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 02300 PARAMED ED PRGM 23.00 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 500, 053 0 0 0 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 0 0 50 00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000 0 0 54.00 54.00 0 0 0 0 0 0 0 0 0 0 0 0 05800 MRI 0 58.00 0 0 58.00 06000 LABORATORY 0 0 60.00 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 0 06600 PHYSI CAL THERAPY 66.00 Ω 0 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07699 LI THOTRI PSY 0 76.99 0 76.99 Λ 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 0 0 90.00 09000 CLI NI C 0 0 0 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 0 500.053 0 0 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 194.00 07951 PHYS THERAPY PERFORMANCE CENTER 0 0 0 0 194.00 0 0 200.00 200.00 Cross Foot Adjustments 0 0 0 201 00 Negative Cost Centers 0 201.00 0 0 0 202.00 TOTAL (sum lines 118 through 201) 500,053 0 202.00

Heal th	Financial Systems	ORTHOPAEDIC HOSP	PT. AT PARKVIEW		In Lie	eu of Form CMS-	2552-10
	LOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/28/2024 8: 5 Total	
		22. 00	23. 00	24.00	25. 00	26.00	
1. 00 (2. 00 (4. 00 (6.	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-BLDG & FIXT DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING D1000 DI ETARY D1100 CAFETERIA D1200 MAINTENANCE OF PERSONNEL D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE D1900 NONPHYSICIAN ANESTHETISTS D2000 I&R SERVICES-SALARY & FRINGES APPRV						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00
23. 00	D2200 1&R SERVICES-OTHER PRGM COSTS APPRV D2300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS	0	0				22. 00 23. 00
	D3000 ADULTS & PEDIATRICS	0	0	8, 649, 9	50 0	8, 649, 950	30. 00
50. 00 6 53. 00 653. 00 654. 00 66. 00 662. 00 662. 00 665. 00 665. 00 665. 00 665. 00 671. 00 671. 00 673. 00 676. 97 66. 98 676. 99 677. 00 678. 00 665.	ANCILLARY SERVICE COST CENTERS D50000 OPERATING ROOM D53000 ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C D58000 MRI D60000 LABORATORY D62000 WHOLE BLOOD & PACKED RED BLOOD CELL D6250 BLOOD CLOTTING FOR HEMOPHILIACS D6500 RESPIRATORY THERAPY D66000 PHYSI CAL THERAPY D6900 ELECTROCARDI OLOGY D77100 MEDI CAL SUPPLIES CHARGED TO PATIENT D7300 DRUGS CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS D7697 CARDI AC REHABILITATION D7698 HYPERBARI C OXYGEN THERAPY D7699 LI THOTRI PSY D77800 CAR T-CELL IMMUNOTHERAPY D77800 CAR T-CELL IMMUNOTHERAPY D90000 CLINI C	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 341, 0' 104, 3i 1, 246, 4i 807, 0' 2, 001, 1i 6, 238, 0i 49, 876, 8i 2, 994, 0'	95 0 06 0 53 0 50 0 0 0 0 0 0 89 0 0 23 0	3, 341, 095 104, 306 1, 246, 453 807, 050 0 2, 001, 189 0 6, 238, 023 49, 876, 897 2, 994, 078 0 0	53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
Ç	10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0 75 0		102. 00
118.00 194.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER	0	0		18 0 32 0	129, 715, 018 1, 332	118. 00 194. 00
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	0 0	0 0 0	129, 716, 3	0 0 0 0 50 0	0	200. 00 201. 00 202. 00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0167

				To	12/31/2023	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/28/2024 8:5	ı allı
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	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	0	0	О	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 356, 095	390, 485		1, 761, 666	0	5. 00
7. 00	00700 OPERATION OF PLANT	0	0	215, 117	215, 117	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	0	102	0	9.00
11. 00	01100 CAFETERI A	0	0	183 0	183 0	0	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	Ö	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	Ö	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	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 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 L&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM	0	0	Ö	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	496, 415	19, 598	516, 013	0	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS		745 404	/ AF 700	4 040 040		1 50 00
50.00	05000 OPERATI NG ROOM	0	715, 104		1, 340, 813	0	50.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	0	0	53. 00 54. 00
58. 00	05800 MRI	0	34, 657	_	41, 643	0	58. 00
60. 00	06000 LABORATORY	O	0 1, 007	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	О	0	0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	26, 649	4	26, 653	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	22, 134	22, 134	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	22, 134	22, 134	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	Ö	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	О	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0		ما	0	00.00
	O9000 CLINIC O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		90. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS				U _I		72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		124, 137		115. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 356, 095	1, 663, 310	1, 028, 954	4, 048, 359	0	118. 00
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	0	0	O	0	n	194. 00
200.00			O		0		200. 00
201.00]	0	o	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 356, 095	1, 663, 310	1, 028, 954	4, 048, 359	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0167

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am

COST CENTER DESCRIPTION ADMINISTRATIVE CENTERS LANDING X							5/28/2024 8: 5	1 am
CENERAL SERVICE COST CENTERS 5.00 7.00 8.00 9.00 10.00		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
CENERAL SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , ,						
GENERAL SERVICE COST CENTRES 1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MUBLE EQUIP 3.00 00500 CAP REL COSTS-MUBLE EQUIP 4.00 0400 CAPPLOVE EBRENET IS DEPARTMENT 5.00 00500 CAPPLOVE CAPPLOVE SERVICE 9.00 00500 CAPPLOVE SERVICE 9.00 00 00 00 00 00 00 00 00 00 00 00 00				7. 00		9. 00	10. 00	
2,00		GENERAL SERVICE COST CENTERS	<u> </u>		•			
2,00	1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4, 00 00400 EMPLOYEE BEREFITS DEPARTMENT								
5.00 00500 ADMINISTRATIVE & GENERAL 1,761,666 7.00 0.700								
7. 00 00700 OPFRATI ON OF PLANT 13, 916 229, 033 7, 00 8, 00 9, 00 00900 AUDREY & 11, 11, 11, 11, 12, 12, 12, 12, 12, 12,			1 761 666					
B. 00 00800 LANDRY & LINEN SERVICE				220 022				
9.00 00900 HOLEKKEEPI NG			1		_			
10.00 01000 01EARY			١	O	l ~			
11. 00 0100 0.0				0		13, 808	F 404	
12. 00 01200 MAINTENANCE OF PERSONNEL 0 0 0 0 0 0 0 0 12. 00				0		0		
13. 00 01300 NURSING ADMINISTRATION 0 0 0 0 0 14. 00 14. 00 01400 CENTRAL SERVICES & SUPPLY 26 0 0 0 0 0 14. 00 15. 00 01500 PHARMACY 26 0 0 0 0 0 0 15. 00 16. 00 01600 MEDICAL RECORDS & LIBRARY 26 0 0 0 0 0 0 0 17. 00 01700 SOCIAL SERVICE 6,791 0 0 0 0 0 0 17. 00 19. 00 01900 NURSING PROGRAM 0 0 0 0 0 0 0 0 0 19. 00 01900 NURSING PROGRAM 0 0 0 0 0 0 0 0 0 19. 00 02000 NURSING PROGRAM 0 0 0 0 0 0 0 0 0 19. 00 02000 NURSING PROGRAM 0 0 0 0 0 0 0 0 0 19. 00 02000 RESTRICES—SALARY & FRI NGES APPRV 0 0 0 0 0 0 0 0 0			1	0	l ~	-		
14. 00 01400 CENTRAL SERVICES & SUPPLY			1	0	l ~	٦		1
15. 00 01500 PHARMACY 26			1	0	0	0		
16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 16.00 17.00 01700 SOCIAL SERVICE 6,791 0 0 0 0 0 19.00 01900 NONPHYSI CI AN ANESTHETISTS 0 0 0 0 0 0 20.00 02000 NURSI NG PROCRAM 0 0 0 0 0 0 21.00 02100 18 SERVI CES-SALARY & FRI NGES APPRV 0 0 0 0 0 0 22.00 02200 18 SERVI CES-SALARY & FRI NGES APPRV 0 0 0 0 0 0 23.00 02300 PASAWED ED PRCM 0 0 0 0 0 0 23.00 02300 PASAWED ED PRCM 0 0 0 0 0 24.00 NURST ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 25.00 NURST ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 26.00 NURST ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 27.00 NURST ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 28.00 NURST ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 0 29.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 20.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 20.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 20.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 20.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 20.00 NURST SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0			1	0	0	0		
17.00 01700 SOCIAL SERVICE 6,791 0 0 0 0 17.00	15. 00		26	0	0	0	0	
19.00 01900 NONPHYSI CI AN AMESTHETI STS 0 0 0 0 0 0 0 0 0	16. 00	01600 MEDICAL RECORDS & LIBRARY		0	C	0	0	16. 00
19.00 01900 NONPHYSI CI AN AMESTHETI STS 0 0 0 0 0 0 0 0 0	17.00	01700 SOCIAL SERVICE	6, 791	0	C	0	0	17. 00
21.00 02100 IAR SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22.00	19.00	01900 NONPHYSICIAN ANESTHETISTS		0	l c	o	0	19. 00
22. 00 02200 12R SERVI CES-OTHER PRGM COSTS APPRV 0 0 0 0 0 0 0 22. 00	20.00	02000 NURSI NG PROGRAM	0	0		o	0	20.00
22. 00 02200 12R SERVI CES-OTHER PRGM COSTS APPRV 0 0 0 0 0 0 0 22. 00	21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0	l c	o	0	21.00
23. 00 0.2300 PARAMED ED PRCM 0 0 0 0 0 23. 00			0	0		0		
IMPATIENT ROUTINE SERVICE COST CENTERS 94,651 89,325 0 5,385 4,305 30.00 ADULTS & PEDI ATRI CS 94,651 89,325 0 5,385 4,305 30.00 ANCI LLARY SERVICE COST CENTERS 50.00 55000 05000 05000 05000 05000 05000 000 0			1	0	ĺ	0		
30. 00 03000 ADULTS & PEDIATRICS 94,651 89,325 0 5,385 4,305 30. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50000 OPERATI NG ROOM 420,531 128,677 0 7,758 0 50. 00 53. 00 53. 00 63.00 ANESTHESI OLOGY 45,376 0 0 0 0 0 53. 00 54. 00 05000 ANESTHESI OLOGY 45,376 0 0 0 0 0 0 54. 00 05800 MRI 16,173 6,236 0 376 0 58. 00 60. 0	20.00		<u> </u>			·1		20.00
ANCILLARY SERVICE COST CENTERS	30 00		04 651	80 325		5 395	4 305	30 00
50. 00 05000 OPERATI NG POOM	30.00		74, 031	07, 323		3, 303	4, 303	30.00
53. 00 05300 ANESTHESI OLOGY 45, 376 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 417 0 0 0 0 0 54. 00 58. 00 05800 MR 16, 173 6, 236 0 0 376 0 58. 00 60. 00 06000 LABORATORY 10, 961 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	EO 00		420 E21	120 477		7 750		E0 00
54. 00								
58. 00 05800 MRI 16, 173 6, 236 0 376 0 58. 00 60. 00 06000 LABORATORY 10, 961 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	1	-		
60. 00 06000 LABORATORY 10,961 0 0 0 0 0 0 60. 00 62. 00 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 62. 00 62. 00 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 62. 30 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00				0	1	-		
62. 00				6, 236	1			
62. 30			1	0	l ~	1 4		
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 660. 00 6600 PHYSI CAL THERAPY 26, 598 4, 795 0 289 0 66. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 69. 00 71. 00 71. 00 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 84, 719 0 0 0 0 0 0 72. 00 1 MPL. DEV. CHARGED TO PATI ENTS 676, 705 0 0 0 0 0 72. 00 73. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 -1	0	l ~	١	-	
66. 00			0	0	0	0	-	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 74. 00	65. 00		0	0	0	0	-	65. 00
71. 00	66. 00		26, 598	4, 795	0	289	-	66. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 676, 705 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 40, 637 0 0 0 0 73. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 09200 OSERVATION BEDS (NON-DISTINCT PART 92. 00 THER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI DI TREATMENT PROGRAM 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS	69. 00		0	0	C	0	0	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 676, 705 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 40, 637 0 0 0 0 73. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 76. 98 76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 09200 OSERVATION BEDS (NON-DISTINCT PART 92. 00 THER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI DI TREATMENT PROGRAM 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84, 719	0	C	0	0	71.00
76. 97	72.00		676, 705	0	C	0	0	72.00
76. 97	73. 00	07300 DRUGS CHARGED TO PATIENTS	40, 637	0		o	0	73.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 0THER REI MBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS	76. 97		1	0	0	o	0	76. 97
76. 99 07699 LITHOTRIPSY 0 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS			0	0		o o	0	
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI DI TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS			1	0	Ĭ		-	
78. 00			1	0			-	•
OUTPATIENT SERVICE COST CENTERS 90. 00			1	0				
90. 00	76.00		U_	0		U U		76.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS 92. 00 OTHER REIMBURSABLE COST CENTERS	00 00		٥	0		ا		00 00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI 0I D TREATMENT PROGRAM O O O O 102.00			U U	Ü		U	Ü	
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS					Т	1		
	102.0		0	0	0	0	0	102. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 303. 467 0 0 0 0 0 115. 00								
			303, 467	0	0	0	0	115. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,761,648 229,033 0 13,808 5,404 118.00	118.0	O SUBTOTALS (SUM OF LINES 1 through 117)	1, 761, 648	229, 033	C	13, 808	5, 404	118. 00
NONREI MBURSABLE COST CENTERS		NONREI MBURSABLE COST CENTERS						
194.00 07951 PHYS THERAPY PERFORMANCE CENTER 18 0 0 0 194.00	194.0	0 07951 PHYS THERAPY PERFORMANCE CENTER	18	0	C	0	0	194. 00
200.00 Cross Foot Adjustments 200.00								
201.00 Negative Cost Centers 0 0 0 0 0 0201.00			0	0	l o	o	0	
202.00 T0TAL (sum lines 118 through 201) 1,761,666 229,033 0 13,808 5,404 202.00			1, 761, 666	229. 033		1		
					'		-,	

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0167

					To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	T alli
	oost denter bescriptron	ON ETERNIA		ADMI NI STRATI (1100000	
					SUPPLY		
		11.00	12.00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						4
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	1 000					10.00
11. 00	01100 CAFETERI A	1, 099	0				11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		0		12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0 651		13. 00 14. 00
15. 00	01500 PHARMACY	0	0		0 651	1	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		1
17. 00	01700 SOCI AL SERVI CE	0	0				1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0				1
20. 00	02000 NURSI NG PROGRAM	0	0		0 0	1	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	ól ő	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0		1
23. 00	02300 PARAMED ED PRGM	0	0		0		1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	91				,	1 20.00
30.00	03000 ADULTS & PEDIATRICS	1, 099	0		0 (0	30.00
	ANCILLARY SERVICE COST CENTERS				<u>'</u>	•	1
50.00	05000 OPERATING ROOM	0	0		0 (0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 (0	53. 00
54.00	05400 RADI 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	
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	-	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 651	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	1	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	1
76. 99	07699 LI THOTRI PSY	0	0		0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	O	0		0 () 0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			I		\	00.00
90.00	09000 CLINIC	0	0		0	0	
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 (102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		O C	<u>) </u>	102.00
115 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	O	0		0 0		115. 00
118. 00	1	1, 099	0		0 651		118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	1,077			<u> </u>	.1 20	1. 10. 00
194 00	07951 PHYS THERAPY PERFORMANCE CENTER	n	0		0 (194. 00
200.00		ı	O			<u> </u>	200. 00
201.00		n	0		0	ol o	201. 00
202.00		1, 099	0		0 651		202.00
_52.50	1.57.12 (3am 11.135 110 till dagil 201)	1,077	0	ı	-1 031	20	,

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0167

					12/31/2023	5/28/2024 8: 5	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSI NG	SERVI CES-SALAR	
	'	RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
		LI BRARY				APPRV	
		16.00	17.00	19. 00	20. 00	21. 00	
	GENERAL SERVICE COST CENTERS		•				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSI NG ADMINI STRATI ON						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		6, 791				17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0, 771	o			19. 00
20. 00	02000 NURSI NG PROGRAM			Ĭ	0		20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV				O	0	1
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRV					J	22. 00
23. 00	02300 PARAMED ED PRGM						23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS)				23.00
30. 00		C	6, 791				30.00
30.00	ANCILLARY SERVICE COST CENTERS		0,771				30.00
50. 00	05000 OPERATING ROOM	(0				50.00
53. 00	05300 ANESTHESI OLOGY		ol o				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			1			54. 00
58. 00	05800 MRI						58. 00
60.00	06000 LABORATORY						60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL						62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS						62. 30
65. 00	06500 RESPIRATORY THERAPY						65. 00
66. 00	06600 PHYSI CAL THERAPY						66. 00
69. 00	06900 ELECTROCARDI OLOGY						69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS						72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS						73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON						76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY						76. 98
76. 99	07699 LI THOTRI PSY						76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION						77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY						78. 00
70.00	OUTPATIENT SERVICE COST CENTERS)				70.00
90 00	09000 CLINIC	C	0				90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	C	0				102. 00
102.00	SPECIAL PURPOSE COST CENTERS)				102.00
115 00		C					115. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	C			^		
118. 00	3 /		6, 791	0	0	0	118. 00
104 04	NONREI MBURSABLE COST CENTERS 0 07951 PHYS THERAPY PERFORMANCE CENTER	C) 0				194. 00
200. 00			ή	0	0	_	200. 00
		_					200.00
201. 00 202. 00		C	1	0	0		201.00
202. U	TIOTAL (Sum TITIES 110 LIMOUGH 201)	1	η ο, /91	ı Y	U	ı	1202.00

	Financial Systems		PT. AT PARKVIEW		111 610	eu of Form CMS-2	2332-10
	TION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0167	Period: From 01/01/2023	Worksheet B	
					To 12/31/2023	Date/lime Pre	
						5/28/2024 8: 5	1 am
		INTERNS &					
		RESI DENTS	0.0.0.0			-	
	Cost Center Description	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
		PRGM COSTS	PRGM		Residents Cost		
		APPRV			& Post		
					Stepdown		
					Adjustments		
	OSMEDAL OSDINIOS COOT OSMEDO	22. 00	23. 00	24.00	25. 00	26. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						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 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 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00	02000 NURSI NG PROGRAM						20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV						21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0					22.00
23. 00	02300 PARAMED ED PRGM		0				23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			1			23.00
20.00	03000 ADULTS & PEDIATRICS			717, 56	9 0	717, 569	20.00
211 (11)							
30. 00				7.7700	,	717, 307	30.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			1, 897, 77	9 0	1, 897, 779	50.00
50. 00 53. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY			1, 897, 77 45, 37	9 0	1, 897, 779 45, 376	50. 00 53. 00
50. 00 53. 00 54. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C			1, 897, 77 45, 37 1, 41	9 0 6 0 7 0	1, 897, 779 45, 376 1, 417	50. 00 53. 00 54. 00
50. 00 53. 00 54. 00 58. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI			1, 897, 77 45, 37 1, 41 64, 42	9 0 6 0 7 0 8 0	1, 897, 779 45, 376 1, 417 64, 428	50. 00 53. 00 54. 00 58. 00
50. 00 53. 00 54. 00 58. 00 60. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961	50. 00 53. 00 54. 00 58. 00 60. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0 1 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0 1 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 0 58, 335	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06550 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY			1, 897, 77 45, 37 1, 41 64, 42 10, 96	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 5 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 0 58, 335	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 5 0 9 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 65. 00 66. 00 69. 00 71. 00 72. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797	50. 00 53. 00 54. 00 58. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADIOLOGY-DIAGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADIOLOGY-DIAGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 65. 00 65. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 00 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 65. 00 65. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 65. 00 65. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 7 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 00 66. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRI PSY 07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 7 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 7 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRI PSY 07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADIOLOGY-DIAGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 001000 CLINIC 09000 OBSERVATION BEDS (NON-DISTINCT PART			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADIOLOGY-DIAGNOSTIC 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 00TPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS			1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHORI PSY 07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINI C 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 92. 00 92. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00 102. 00 115. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINI C 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10200 OPI OID TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS		0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 5 0 0 0 9 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 92. 00 92. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00 102. 00 115. 00 118. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRI PSY 07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117)		0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 90. 00 92. 00 115. 00 118. 00 194. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11500 AMBURSABLE COST CENTERS 10501 AMBURSABLE COST CENTERS 10502 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS		0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79 427, 60 4, 048, 34	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 427, 604 4, 048, 341	50. 00 53. 00 54. 00 58. 00 60. 00 62. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00
50. 00 53. 00 54. 00 60. 00 62. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00 115. 00 118. 00 194. 00 200. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER	0	0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79 427, 60 4, 048, 34	9 0 6 0 7 0 8 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 427, 604 4, 048, 341	50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 90. 00 92. 00 102. 00 115. 00 118. 00 200. 00
50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 90. 00 92. 00 115. 00 118. 00 194. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDIOLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS 11500 AMBULATORY SURGICAL CENTER (D. P.) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments Negative Cost Centers		0	1, 897, 77 45, 37 1, 41 64, 42 10, 96 58, 33 84, 71 677, 35 62, 79 427, 60 4, 048, 34	9 0 6 0 7 0 8 0 11 0 00 0 00 0 00 0 5 0 00 0 00 0 00	1, 897, 779 45, 376 1, 417 64, 428 10, 961 0 0 58, 335 0 84, 719 677, 356 62, 797 0 0 0 0 0 427, 604 4, 048, 341	50. 00 53. 00 54. 00 58. 00 60. 00 62. 30 65. 00 66. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 77. 00 78. 00 92. 00 102. 00 115. 00 118. 00 200. 00 201. 00

Heal th Fi	nancial Systems	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	eu of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·
						5/28/2024 8: 5	1 am
		CAPI TAL REI	LATED COSTS				
	Cost Contor Dosgrintion	DIDC 0 FLVT	MVDLE FOLLD	EMDLOVEE	Doconci Li ati on	ADMINISTRATIVE	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	
		(SQUARE TELT)	(DOLLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS		(1000)	
				SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
	NERAL SERVICE COST CENTERS	7, 770	1	1			
	0100 CAP REL COSTS-BLDG & FLXT	74, 773					1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 666, 513 0		1		2. 00 4. 00
1	D500 ADMINISTRATIVE & GENERAL	17, 554	_			92, 985, 125	5.00
	0700 OPERATION OF PLANT	0	766, 535			734, 509	7. 00
	0800 LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
	9900 HOUSEKEEPI NG	0	0	519, 51°	1 0	728, 799	9. 00
	000 DI ETARY	0	653	238, 30	5 0	275, 570	
	100 CAFETERI A	0	0	(0	0	
	200 MAI NTENANCE OF PERSONNEL	0	0	1	0	0	
	300 NURSI NG ADMI NI STRATI ON	0	0	20. 72:	7 0	0	13. 00 14. 00
	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	0	0	29, 72 ⁻ 1, 18		34, 353 1, 373	1
	600 MEDICAL RECORDS & LIBRARY	0	0		0 0	1,3/3	ı
	700 SOCI AL SERVI CE	0	0	226, 67	-	358, 455	1
	900 NONPHYSI CI AN ANESTHETI STS	0	Ö	223, 37	0 0	0	1
	2000 NURSING PROGRAM	0	0		0 0	0	20.00
	100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
	2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22. 00
	2300 PARAMED ED PRGM	0	0	(0	0	23. 00
	IPATI ENT ROUTI NE SERVI CE COST CENTERS	00.047	1 (0.004	0 000 07	,	4 005 040	00.00
	ADULTS & PEDIATRICS	22, 316	69, 834	3, 332, 27	6 0	4, 995, 849	30. 00
	ICILLARY SERVICE COST CENTERS OOO OPERATING ROOM	32, 147	2, 229, 612	10, 423, 81	8 0	22, 196, 282	50.00
	3300 ANESTHESI OLOGY	32, 147	2, 227, 012		0 0		
	5400 RADI OLOGY-DI AGNOSTI C	0	Ö	64, 69	-	74, 770	
	5800 MRI	1, 558	24, 892			853, 656	1
	0000 LABORATORY	0	0	486, 220		578, 521	•
62.00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
	5500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
1	600 PHYSI CAL THERAPY	1, 198	16	1, 173, 19	3 0	1, 403, 883	
	9900 ELECTROCARDIOLOGY 1000 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	07.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	4, 471, 627 35, 719, 132	
	7300 DRUGS CHARGED TO PATIENTS		78, 872	799, 99	6 0	2, 144, 884	1
	7697 CARDI AC REHABI LI TATI ON	0	0	,,,,,	0 0	2,111,001	1
	698 HYPERBARIC OXYGEN THERAPY	0	0		0	0	1
76. 99 07	'699 LI THOTRI PSY	0	0		0	0	76. 99
	7700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	
	'800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
	TPATIENT SERVICE COST CENTERS	1	1	1			00.00
	2000 CLINIC 2200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0	0	90. 00 92. 00
	HER REIMBURSABLE COST CENTERS						92.00
	2200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102. 00
	PECIAL PURPOSE COST CENTERS				<u> </u>		102.00
	500 AMBULATORY SURGICAL CENTER (D. P.)	0	442, 342	6, 001, 21	1 0	16, 017, 496	115. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	74, 773	3, 666, 513	35, 321, 87	2 -36, 731, 225	92, 984, 170	118. 00
	NREI MBURSABLE COST CENTERS						
1	'951 PHYS THERAPY PERFORMANCE CENTER	0	0	6'	9 0	955	194. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	1 //2 210	1 000 054	F 407 20	,	27 724 225	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 663, 310	1, 028, 954	5, 496, 39	D	36, 731, 225	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	22. 244794	0. 280636	0. 15560	9	0. 395023	203 00
204. 00	Cost to be allocated (per Wkst. B,		0.20000	0.10000	Ö	1, 761, 666	
	Part II)					, , , , , , , ,	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000	O	0. 018946	205. 00
	11)	1					1
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	1					207. 00
207. 00	Parts III and IV)						207.00
'		1	1	•	1	•	'

Health Financial Systems ORTHOPAEDI C HOSPT. AT PARKVI EW In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0167 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (MEALS SERVED) (MEALS SERVED) PLANT LINEN SERVICE (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 7.00 00700 OPERATION OF PLANT 57, 219 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 0 57, 219 9.00 10.00 01000 DI ETARY 0 24.486 10.00 01100 CAFETERI A 0000000 4, 978 10, 000 11.00 0 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 0 Λ 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 0 01500 PHARMACY 0 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 0 19.00 02000 NURSI NG PROGRAM 0 20.00 Ω 0 20 00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 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 0 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 22, 316 0 22, 316 19, 508 10,000 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 32 147 n n 50 00 32 147 O 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 C 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 58.00 05800 MRI 1,558 0 0 58.00 1,558 0 06000 LABORATORY 60 00 Ω 60 00 0 C 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 62.30 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 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 0 76 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 07699 LI THOTRI PSY 0 76.99 76.99 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 O 0 77.00 r 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 0 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 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) 57, 219 Ω 57, 219 24, 486 10, 000 118. 00 NONREI MBURSABLE COST CENTERS 194. 00 07951 PHYS THERAPY PERFORMANCE CENTER 0 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1,024,657 1, 016, 691 384, 426 78, 154 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17. 907636 0.000000 17.768416 15. 699828 7. 815400 203. 00 204.00 Cost to be allocated (per Wkst. B, 229,033 13,808 5, 404 1, 099 204. 00 Part II) 0. 109900 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 4.002744 0.000000 0. 241318 0. 220698 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

Heal th	Financial Systems	ORTHOPAEDIC HOSI	PT. AT PARKVIEW		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC	F	reriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/28/2024 8:5	pared:
	Cost Center Description	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		12. 00	13. 00	14. 00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS	<u> </u>	<u> </u>				1
13. 00 14. 00 15. 00 16. 00 17. 00 19. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	000000000000000000000000000000000000000	0 0 0 0 0 0	10, 000 0 0 0 0 0 0 0	10, 000 0 0 0 0 0 0	0 0 0 0 0	22. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00	03000 ADULTS & PEDIATRICS	0	0	C	0	0	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	O	C	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	Ö	o o	O		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
58. 00	05800 MRI	0	0	C	0	0	58. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	10, 000		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	10, 000	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	C	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	Ü	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0		0	76. 99
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	
76.00	OUTPATIENT SERVICE COST CENTERS		U U		v _I V _I	U	78. 00
90 00	09000 CLINIC	0	0	C	0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			Č			92. 00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		C			115. 00
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	0	0	10, 000	10, 000	0	118. 00
104.00	NONREI MBURSABLE COST CENTERS	0	ا	0	ا	0	104 00
200.00	07951 PHYS THERAPY PERFORMANCE CENTER Cross Foot Adjustments	0	U U	U	o o	U	194. 00 200. 00
200.00	, ,						201. 00
202.00	1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	0	0	47, 923	1, 915	0	202. 00
202.00	Part I)			47, 725	1, 713	0	202.00
203.00		0. 000000	0. 000000	4. 792300	0. 191500	0. 000000	203. 00
204.00		0	О	651	26		204.00
	Part II)						
205.00		0. 000000	0. 000000	0. 065100	0. 002600	0. 000000	205. 00
206. 00							206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	,	1	'		ı	ı	1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0167

				T	O 12/31/2023	5/28/2024 8: 5	
	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	ANESTHETI STS (ASSI GNED	NURSI NG PROGRAM (ASSI GNED	SERVI CES-SALAR Y & FRI NGES APPRV	PRGM COSTS APPRV	
			TIME)	TI ME)	(ASSI GNED TIME)	(ASSI GNED TIME)	
		17. 00	19. 00	20.00	21.00	22.00	
	RAL SERVICE COST CENTERS O CAP REL COSTS-BLDG & FIXT			1			1.00
	O CAP REL COSTS-MVBLE EQUIP						2. 00
1	O EMPLOYEE BENEFITS DEPARTMENT						4. 00
1	O ADMINISTRATIVE & GENERAL O OPERATION OF PLANT						5. 00 7. 00
	O LAUNDRY & LINEN SERVICE						8. 00
	O HOUSEKEEPI NG						9.00
	O DI ETARY O CAFETERI A						10. 00 11. 00
	MAINTENANCE OF PERSONNEL						12. 00
	O NURSI NG ADMI NI STRATI ON						13.00
	O CENTRAL SERVICES & SUPPLY O PHARMACY						14. 00 15. 00
1	O MEDICAL RECORDS & LIBRARY						16. 00
	O SOCIAL SERVICE O NONPHYSICIAN ANESTHETISTS	10,000	0				17. 00 19. 00
	O NURSI NG PROGRAM	0		C			20.00
	O I &R SERVI CES-SALARY & FRINGES APPRV	0			0		21. 00
	O &R SERVICES-OTHER PRGM COSTS APPRV O PARAMED ED PRGM	0				0	22. 00
I NPA	TIENT ROUTINE SERVICE COST CENTERS						20.00
	O ADULTS & PEDIATRICS	10, 000	0	<u>C</u>	0	0	30.00
	LLARY SERVICE COST CENTERS O OPERATING ROOM	1 0	0	C	ol	0	50.00
53. 00 0530	O ANESTHESI OLOGY	0	0	o c	O	0	53. 00
	O RADI OLOGY-DI AGNOSTI C	0	0	O	-	0	
	O MRI O LABORATORY			C	_	0	
62. 00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	O	0	62. 00
4	O BLOOD CLOTTING FOR HEMOPHILIACS O RESPIRATORY THERAPY	0	0	0	-	0	62. 30 65. 00
	O PHYSI CAL THERAPY	0	0	d	-	0	66.00
1	0 ELECTROCARDI OLOGY	0	0	C	-	0	
1	O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
	O DRUGS CHARGED TO PATIENTS	0	Ö	ď	-	0	
1	7 CARDI AC REHABI LI TATI ON	0	0	C	-	0	1
1	8 HYPERBARI C OXYGEN THERAPY 9 LI THOTRI PSY	0	0	C	-	0	76. 98 76. 99
	O ALLOGENEIC HSCT ACQUISITION	0	0	d	-	0	77. 00
	O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	78. 00
	O CLINIC	0	0	C	O	0	90.00
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	R REIMBURSABLE COST CENTERS O OPIOID TREATMENT PROGRAM	T 0	0	C	ol	0	102. 00
	I AL PURPOSE COST CENTERS				y o		102.00
	O AMBULATORY SURGICAL CENTER (D. P.)	0					115. 00
118. 00 NONR	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	10, 000	0	C	0	0	118. 00
	1 PHYS THERAPY PERFORMANCE CENTER	0	0	C	0	0	194. 00
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	500, 053	0	C	o	0	201. 00 202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	50. 005300	0. 000000	0.000000	0.000000	0.000000	
204. 00	Cost to be allocated (per Wkst. B, Part II)	6, 791				Ü	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 679100	0. 000000	0.000000	0. 000000	0.000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)			С			206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000			207. 00
	Parts III and IV)						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 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am 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 PROGRAM 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 23.00 02300 PARAMED ED PRGM 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM O 50 00 05300 ANESTHESI OLOGY 0 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 00000000000000 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 76. 98 07699 LI THOTRI PSY 76.99 76.99 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115.00 0 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 0 118.00 194. 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 Cost to be allocated (per Wkst. B, 0 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205.00 0.000000 205.00 II)206.00 NAHE adjustment amount to be allocated 0 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

Health Financial Systems	ORTHOPAEDIC HOSE				u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/28/2024 8:5	pared: 1 am
		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 & PEDIATRICS	8, 649, 950		8, 649, 950	0	8, 649, 950	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	32, 111, 202		32, 111, 20:	2 0	32, 111, 202	
53. 00 05300 ANESTHESI OLOGY	3, 341, 095		3, 341, 09	5 0	3, 341, 095	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	104, 306		104, 30	6 0	104, 306	
58. 00 05800 MRI	1, 246, 453		1, 246, 45	3 0	1, 246, 453	
60. 00 06000 LABORATORY	807, 050		807, 050	0	807, 050	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 001, 189	0	2, 001, 18	9 0	2, 001, 189	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0			0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 238, 023		6, 238, 02	3 0	6, 238, 023	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49, 876, 897		49, 876, 89	7 0	49, 876, 897	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 994, 078		2, 994, 07	8 0	2, 994, 078	73.00
76. 97 07697 CARDIAC REHABILITATION	0			0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
76. 99 07699 LI THOTRI PSY	0			0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
90. 00 09000 CLI NI C	0			0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	357, 436		357, 43	6	357, 436	92.00
OTHER REIMBURSABLE COST CENTERS				•		1
102, 00 10200 OPLOLD TREATMENT PROGRAM	0		(0	0	102.00

22, 344, 775

130, 072, 454 357, 436 129, 715, 018

22, 344, 775

130, 072, 454 357, 436 129, 715, 018 0 102. 00

22, 344, 775 130, 072, 454 200. 00 357, 436 201. 00 129, 715, 018 202. 00

102.00 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS

200.00

201. 00 202. 00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds Total (see instructions)

Subtotal (see instructions)

Heal th	Financial Systems	ORTHOPAEDI C HOSP	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre	pared:
						5/28/2024 8:5	1 am
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 891, 613		2, 891, 61	3		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	36, 131, 052	238, 764, 839	274, 895, 89	0. 116812	0.000000	50.00
53.00	05300 ANESTHESI OLOGY	4, 579, 183	19, 761, 649	24, 340, 83	2 0. 137263	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	881, 201	6, 509, 428	7, 390, 62	9 0. 014113	0.000000	54.00
	I I	1 1		1			1

Health Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023 Worksheet C Part I Date/Ti me Prepared: 5/28/2024 8:51 am		

				5/28/2024 8:51 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 116812			50.00
53. 00 05300 ANESTHESI OLOGY	0. 137263			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 014113			54. 00
58. 00 05800 MRI	0. 173497			58. 00
60. 00 06000 LABORATORY	0. 186728			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 345530			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 192446			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262370			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 154519			73. 00
76. 97 07697 CARDIAC REHABILITATION	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
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 053178			92. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	ORTHOPAEDI C HOSI	DT AT DARKVIEW		Inlie	eu of Form CMS-2	2552_10
COMPUTATION OF RATIO OF COSTS TO CHARGES	OKTIOI ALDI C TIOSI	Provi der C	CN: 15-0167	Period: From 01/01/2023 Fo 12/31/2023	Worksheet C Part I Date/Time Pre 5/28/2024 8:5	pared:
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		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	8, 649, 950		8, 649, 950	0	8, 649, 950	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	32, 111, 202		32, 111, 202	2 0	32, 111, 202	50. 00
53. 00 05300 ANESTHESI OLOGY	3, 341, 095		3, 341, 09!	5 0	3, 341, 095	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	104, 306		104, 300	6 0	104, 306	54.00
58. 00 05800 MRI	1, 246, 453		1, 246, 453	3 0	1, 246, 453	58. 00
60. 00 06000 LABORATORY	807, 050		807, 050	0	807, 050	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 001, 189		2, 001, 189	9 0	2, 001, 189	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0			0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 238, 023		6, 238, 023	3 0	6, 238, 023	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49, 876, 897		49, 876, 89	7 0	49, 876, 897	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 994, 078		2, 994, 078	3 0	2, 994, 078	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		(0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
76. 99 07699 LI THOTRI PSY	0			0	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				<u> </u>		1
90. 00 09000 CLI NI C	0			0	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	357, 436		357, 436		357, 436	
OTHER REIMBURSABLE COST CENTERS	007,100	<u> </u>	007, 100	21	307, 100	1 .2.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			ol .	0	102. 00

22, 344, 775

130, 072, 454 357, 436 129, 715, 018

22, 344, 775

130, 072, 454 357, 436 129, 715, 018

22, 344, 775 130, 072, 454 200. 00 357, 436 201. 00 129, 715, 018 202. 00

0

102.00 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS

200.00

201.00 202.00

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds Total (see instructions)

Subtotal (see instructions)

Heal th	Financial Systems	ORTHOPAEDIC HOSE	T. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 891, 613		2, 891, 61	3		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	36, 131, 052	238, 764, 839	274, 895, 89	0. 116812	0.000000	50.00
E2 00	OF 200 AMESTURGLOLOGY	4 570 100	10 7/1 //0	24 240 02	0 127242	0.000000	E2 00

			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						
30.00	03000 ADULTS & PEDIATRICS	2, 891, 613		2, 891, 613			30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	36, 131, 052	238, 764, 839	274, 895, 891	0. 116812	0.000000	50. 00
53.00	05300 ANESTHESI OLOGY	4, 579, 183	19, 761, 649	24, 340, 832	0. 137263	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	881, 201	6, 509, 428	7, 390, 629	0. 014113	0.000000	54.00
58.00	05800 MRI	18, 031	7, 166, 265	7, 184, 296	0. 173497	0.000000	58. 00
60.00	06000 LABORATORY	1, 015, 634	3, 306, 429	4, 322, 063	0. 186728	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0	0.000000	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 077, 986	4, 713, 658	5, 791, 644	0. 345530	0.000000	66. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	0	0.000000	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 701, 565	25, 712, 781	32, 414, 346	0. 192446	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	40, 113, 831	149, 987, 366	190, 101, 197	0. 262370	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 628, 165	15, 748, 570	19, 376, 735	0. 154519	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	0	0.000000	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0	0	0.000000	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	o	0	0	0.000000	0.000000	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o	0	0	0.000000	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	o	0	0	0.000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0.000000	0.000000	90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 721, 510	6, 721, 510	0. 053178	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0			102. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	104, 964, 899	104, 964, 899			115. 00
200.00	Subtotal (see instructions)	97, 038, 261	583, 357, 394	680, 395, 655			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	97, 038, 261	583, 357, 394	680, 395, 655			202. 00
				•	. '	'	•

Health Financial Systems	ORTHOPAEDIC HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/28/2024 8:5	
		Title XIX	Hospi tal	PPS	

				5/28/2024 8:51 8	am
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	30. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 116812			5	50.00
53. 00 05300 ANESTHESI OLOGY	0. 137263			5	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 014113			5	54. 00
58. 00 05800 MRI	0. 173497			5	8. 00
60. 00 06000 LABORATORY	0. 186728			6	50.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			6	52.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			6	52. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000			6	55.00
66. 00 06600 PHYSI CAL THERAPY	0. 345530			6	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			6	59. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 192446			7	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262370			7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 154519			7	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			7	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			7	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			7	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			7	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			7	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000			9	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 053178			9	92. 00
OTHER REIMBURSABLE COST CENTERS					
102. 00 10200 OPI OI D TREATMENT PROGRAM				10	02.00
SPECIAL PURPOSE COST CENTERS					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				11	15. 00
200.00 Subtotal (see instructions)				20	00.00
201.00 Less Observation Beds				20	01.00
202.00 Total (see instructions)				20	02.00
				•	

Health Financial Systems	ORTHOPAEDIC HOSPT. A	AT PARKVIEW	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE C	OST TO CHARGE RATIOS NET OF	Provider CCN: 15-0167	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 01/01/2023	

KEDOOT	TONS FOR WEDICALD UNEI			Ť	o 12/31/2023	Date/Time Pre 5/28/2024 8:5	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part			Reduction	Reduction	
		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						
50.00	05000 OPERATING ROOM	32, 111, 202	1, 897, 779	30, 213, 423	0	0	50.00
53.00	05300 ANESTHESI OLOGY	3, 341, 095	45, 376	3, 295, 719	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	104, 306	1, 417	102, 889	0	0	54. 00
58.00	05800 MRI	1, 246, 453	64, 428	1, 182, 025	0	0	58. 00
60.00	06000 LABORATORY	807, 050	10, 961	796, 089	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 001, 189	58, 335	1, 942, 854	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 238, 023	84, 719	6, 153, 304	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	49, 876, 897	677, 356	49, 199, 541	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 994, 078	62, 797	2, 931, 281	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	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	357, 436	29, 651	327, 785	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	22, 344, 775	427, 604	21, 917, 171	0	0	115. 00
200.00	Subtotal (sum of lines 50 thru 199)	121, 422, 504	3, 360, 423	118, 062, 081	0	0	200. 00
201.00	Less Observation Beds	357, 436	29, 651	327, 785	0	0	201. 00
202.00	Total (line 200 minus line 201)	121, 065, 068	3, 330, 772	117, 734, 296	0	0	202. 00

Health Financial Systems	ORTHOPAEDI C HOSPT. A	AT PARKVIEW	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE REDUCTIONS FOR MEDICALD ONLY	COST TO CHARGE RATIOS NET OF	Provider CCN: 15-0167	From 01/01/2023	Worksheet C Part II Date/Time Prepared:

				'		5/28/2024 8:5	51 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges	Outpati ent			
				Cost to Charge			
		Operating Cost					
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATI NG ROOM	32, 111, 202	274, 895, 891				50.00
	05300 ANESTHESI OLOGY	3, 341, 095	24, 340, 832				53. 00
	05400 RADI OLOGY-DI AGNOSTI C	104, 306	7, 390, 629				54. 00
58. 00	05800 MRI	1, 246, 453	7, 184, 296	•			58. 00
60.00	06000 LABORATORY	807, 050	4, 322, 063				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000			62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	0.000000			65.00
66. 00	06600 PHYSI CAL THERAPY	2, 001, 189	5, 791, 644				66. 00
	06900 ELECTROCARDI OLOGY	0	0	0.000000			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 238, 023	32, 414, 346				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	49, 876, 897	190, 101, 197	0. 262370)		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 994, 078	19, 376, 735	0. 154519			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.000000)		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.000000)		76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.000000			76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000			77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000)		78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.000000)		90. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	357, 436	6, 721, 510	0. 053178	3		92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0.000000)		102. 00
	SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	22, 344, 775	104, 964, 899	0. 212879			115. 00
200.00	Subtotal (sum of lines 50 thru 199)	121, 422, 504	677, 504, 042				200.00
201.00	Less Observation Beds	357, 436	0				201.00
202.00	Total (line 200 minus line 201)	121, 065, 068	677, 504, 042				202. 00

Health Financial Systems	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023		pared: 1 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capi tal Rel ated Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col. 26)		(col . 1 - col 2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	717, 569	0	717, 56	9 1, 210	593. 03	30.00
200.00 Total (lines 30 through 199)	717, 569		717, 56	9 1, 210		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
LANDATI ENT. DOUTLANE OFFICE OF COOT OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDI ATRI CS	278					30. 00
200.00 Total (lines 30 through 199)	278	164, 862				200. 00

Health Financial Systems C	ORTHOPAEDIC HOS	PT AT PARKVIEW		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0167	Peri od:	Worksheet D	2332 10
THE OWN DESIGNATION OF THE PROPERTY OF THE PRO	L 00010	110vruei 0		From 01/01/2023	Part II	
				To 12/31/2023		pared:
		T: 41 -		11! 4-1	5/28/2024 8: 5	1 am
Cost Conton Decement on	Coni tol	Total Charges	XVIII	Hospi tal	PPS Capital Costs	
Cost Center Description	Capi tal	(from Wkst. C,		Inpatient Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)	. Charges	COTUINIT 4)	
	26))	2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		2.00	0.00		0.00	
50. 00 05000 OPERATING ROOM	1, 897, 779	274, 895, 891	0.00690	4 9, 089, 762	62, 756	50.00
53. 00 05300 ANESTHESI OLOGY	45, 376					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 417	7, 390, 629	0. 00019	2 38, 823	7	54. 00
58. 00 05800 MRI	64, 428	7, 184, 296	0. 00896	8 1, 883	17	58. 00
60. 00 06000 LABORATORY	10, 961	4, 322, 063	0. 00253	6 301, 079	764	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.00000	0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	0.00000		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	58, 335	5, 791, 644			2, 691	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84, 719		1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	677, 356					
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 797	19, 376, 735		·		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000		0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1		ما ما		
90. 00 09000 CLI NI C	20 (51	(721 510	0.00000		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	29, 651		1		0 111, 846	
200.00 Total (lines 50 through 199)	2, 932, 819	572, 539, 143	1	23, 582, 931	111,846	J200. 00

Health Financial Systems 0	RTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2023 To 12/31/2023		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	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 & PEDIATRICS 200.00 Total (Lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	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 & PEDLATRICS 200.00 Total (lines 30 through 199)	0	0	1, 21 1, 21			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems	ORTHOPAEDI C HOSPT	. AT PARKVIEW	AT PARKVIEW		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provider Co	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/28/2024 8:5		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Non Physician Anesthetist	Nursi ng Program	Nursi ng Program	Allied Health Post-Stepdown			

					5/28/2024 8: 5	1 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
58. 00 05800 MRI	0	0	C	0	0	58. 00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	C	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	l	0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	l	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
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1		0	92. 00
200.00 Total (lines 50 through 199)		0	1	0	1 0	200.00
	1	1	1	.1	,	

Health Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW In Lieu of Form CMS-2552-1							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS				Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre	pared:	
			\0.00 L		5/28/2024 8: 5	<u>1 am</u>	
0 1 0 1 0 1 1	ALL 011		XVIII	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total	(from Wkst. C,	Ratio of Cost		
	Medical		Outpatient Cost (sum of		to Charges (col. 5 ÷ col.		
	Education Cost	1, 2, 3, and 4)	cols. 2, 3,	8)	`		
		4)	and 4)	0)	7) (see		
			aliu 4)		instructions)		
	4.00	5.00	6. 00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00		
50. 00 05000 OPERATI NG ROOM	0	0		0 274, 895, 891	0.000000	50.00	
53. 00 05300 ANESTHESI OLOGY	0	0	1	0 24, 340, 832			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 7, 390, 629			
58. 00 05800 MRI	0	0		0 7, 184, 296			
60. 00 06000 LABORATORY	0	0		0 4, 322, 063			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	l o		0 0	0. 000000		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0.000000	1	
65. 00 06500 RESPI RATORY THERAPY	0	l o		o o	0. 000000		
66. 00 06600 PHYSI CAL THERAPY	0	l o		5, 791, 644			
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 32, 414, 346			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 190, 101, 197		72. 00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 19, 376, 735	0.000000	73. 00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.000000	76. 97	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		o o	0.000000	76. 98	
76. 99 07699 LI THOTRI PSY	0	0		o o	0.000000	76. 99	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		o o	0.000000	77. 00	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		o o	0.000000	78. 00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 6, 721, 510	0.000000	92.00	
200.00 Total (lines 50 through 199)	0	0		0 572, 539, 143		200. 00	

	<u> </u>	ORTHOPAEDIC HOSP				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		RVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2023 To 12/31/2023		pared:
			T' 11	\0.41 L L		5/28/2024 8: 5	1 am
		1		XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col. 8	3	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
	ANOLILIA DIVI OFFICIA CONT. OFFITEDO	9.00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS		0.000.7/0	Ι	0 440 504		
50. 00	05000 OPERATING ROOM	0. 000000	9, 089, 762		0 39, 143, 506	0	50.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	1, 112, 624		0 3, 011, 329	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38, 823		0 143, 472	0	54.00
58. 00	05800 MRI	0. 000000	1, 883		0 688, 736	0	58.00
60. 00	06000 LABORATORY	0. 000000	301, 079		0 587, 326	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	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	267, 135		0 1, 069, 117	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 802, 723		0 3, 395, 318	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 167, 712		0 27, 880, 179	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	801, 190		0 2, 461, 605	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		o o	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		o o	0	77. 00
78. 00		0. 000000	0		0	0	78.00
	OUTPATIENT SERVICE COST CENTERS						1
90. 00	09000 CLINIC	0.000000	0		0 0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 14, 988	0	
200. 00		2.000000	23, 582, 931		0 78, 395, 576	0	200.00

Health Financial Systems	Financial Systems ORTHOPAEDIC HOSPT. AT PARKVIEW			u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER H	ALTH SERVICES AND VACCINE COST	Provider CCN: 15-0167	Peri od:	Worksheet D
			From 01/01/2023	Part V

	ONNERT OF MEDICAL, OTHER REALTH SERVICES AND	VACOTIVE COST		F	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/28/2024 8:5	
			Title	XVIII	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description	Cost to Charge			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.		
		1.00		(see inst.)	(see inst.)		
-	ANOLILIADY OFFICE OF COST OFFITTED	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		00 110 501	1		1 570 404	
	05000 OPERATING ROOM	0. 116812	39, 143, 506		0	4, 572, 431	1
	05300 ANESTHESI OLOGY	0. 137263	3, 011, 329		0	413, 344	1
	05400 RADI OLOGY-DI AGNOSTI C	0. 014113	143, 472		0	2, 025	1
	05800 MRI	0. 173497	688, 736		0	119, 494	1
1	06000 LABORATORY	0. 186728	587, 326	(0	109, 670	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	(0	0	02.00
1	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(0	0	62. 30
	06500 RESPI RATORY THERAPY	0. 000000	0	(0	0	65. 00
	06600 PHYSI CAL THERAPY	0. 345530	1, 069, 117	(0	369, 412	
1	06900 ELECTROCARDI OLOGY	0. 000000	0	(0	0	07.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 192446	3, 395, 318		0	653, 415	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262370	27, 880, 179		0	7, 314, 923	1
1	07300 DRUGS CHARGED TO PATIENTS	0. 154519	2, 461, 605		0	380, 365	
	07697 CARDIAC REHABILITATION	0. 000000	0	(0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0. 000000	0	(0	0	76. 98
	07699 LI THOTRI PSY	0. 000000	0	(0	0	76. 99
1	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	(0	0	1 ,0.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 053178	14, 988	(0	797	
200.00	Subtotal (see instructions)		78, 395, 576	(0	13, 935, 876	200. 00
201.00	Less PBP Clinic Lab. Services-Program			(0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		78, 395, 576	(0	13, 935, 876	202. 00

alth Financial Systems	ORTHOPAEDI C HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-:	2552-10
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVIO	CES AND VACCINE COST	Provider CO	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/28/2024 8:5	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				

Cost Center Description	Cost	Cost		
	Rei mbursed	Reimbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6. 00	7. 00		
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0	0		50.00
53. 00 05300 ANESTHESI OLOGY	0	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54. 00
58. 00 05800 MRI	0	0		58. 00
60. 00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
76. 99 07699 LI THOTRI PSY	0	0		76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
OUTPATIENT SERVICE COST CENTERS			1	
90. 00 09000 CLI NI C	0	0		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92. 00
200.00 Subtotal (see instructions)	0	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0			201. 00
Only Charges				
202.00 Net Charges (line 200 - line 201)	0	0		202. 00
	•	•	•	•

Health Financial Systems C	RTHOPAEDIC HOS	PT. AT PARKVIEW		In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		T: ±1	- VIV	11: +-1	5/28/2024 8: 5	1 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	•	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	717, 569	0	717, 56	9 1, 210	593. 03	30.00
200.00 Total (lines 30 through 199)	717, 569		717, 56	9 1, 210		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 ADULTS & PEDIATRICS	6	3, 558	3			30.00
200.00 Total (lines 30 through 199)	6	3, 558	8			200. 00

Health Financial Systems C	ORTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od: From 01/01/2023	Worksheet D Part II	
				To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		1,	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	1	1			
50. 00 05000 OPERATI NG ROOM	1, 897, 779		l .			
53. 00 05300 ANESTHESI OLOGY	45, 376					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 417		l .		0	
58. 00 05800 MRI	64, 428		l .		0	
60. 00 06000 LABORATORY	10, 961	4, 322, 063			16	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000		0	02.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	02.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0. 00000		0	00.00
66. 00 06600 PHYSI CAL THERAPY	58, 335	5, 791, 644			45	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	0 / 1 0 0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84, 719				17	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	677, 356					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 797	19, 376, 735			43	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000		0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLINIC	0	0			_	, , , , , ,
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	29, 651				0	1 /2.00
200.00 Total (lines 50 through 199)	2, 932, 819	572, 539, 143	l	422, 291	2, 003	200. 00

Health Financial Systems	(ORTHOPAEDIC HOSE	PT. AT PARKVIEW		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHER PA	ASS THROUGH COST	rs Provider C	F	Period: From 01/01/2023 To 12/31/2023		pared:
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Des	cri pti on	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
		1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SER	VICE COST CENTERS						
30. 00 03000 ADULTS & PEDIAT 200. 00 Total (lines 30		0 0	0	(0	0	30. 00 200. 00
Cost Center Des		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	200.00
		4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SER	VICE COST CENTERS						
30.00 03000 ADULTS & PEDIAT 200.00 Total (lines 30		0	0	1, 210 1, 210			30. 00 200. 00
Cost Center Des		Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SER							
30. 00 03000 ADULTS & PEDIAT 200. 00 Total (lines 30		0					30. 00 200. 00

Health Financial Systems	ORTHOPAEDI C HOSF	u of Form CMS-2	552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CO	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/28/2024 8:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursi ng Program	Nursi ng Program	Allied Health Post-Stepdown		

						5/28/2024 8:5	ı am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0		0	0	50.00
53.00 05300	ANESTHESI OLOGY	0	0		0	0	53. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
58.00 05800	MRI	0	0		0	0	58. 00
	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	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	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0	0		0	0	76. 98
76. 99 07699	LI THOTRI PSY	0	0		0	0	76. 99
	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	ATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	C		0 0	0	90. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Hoal th	Financial Systems	ORTHOPAEDI C HOSI	OT AT DADKVIEW		In Lie	eu of Form CMS-2	2552_10
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEIGH COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCI LLARY SERVI CE COST CENTERS	_	_	Т			
50. 00		0	0		0 274, 895, 891		
53. 00	05300 ANESTHESI OLOGY	0	0		0 24, 340, 832		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 7, 390, 629		
58. 00	05800 MRI	0	0		0 7, 184, 296		
60.00	06000 LABORATORY	0	0		0 4, 322, 063		
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	
65.00	06500 RESPI RATORY THERAPY	0	0		0	0.000000	
66. 00	1 1	0	0		5, 791, 644		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 32, 414, 346	0.000000	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 190, 101, 197	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 19, 376, 735	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	0.000000	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS]
90.00	09000 CLI NI C	0	0		0 0	0.000000	90.00
92 00	109200 OBSERVATION BEDS (NON-DISTINCT PART	0	l		n 6 721 510	0 000000	92 00

0 0 0

0 0 0

6, 721, 510 572, 539, 143

0.000000

90. 00 92. 00

200. 00

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

Health Financial Systems	DTUODAEDI C UOSD	T AT DADKVIEW		ln li c	u of Form CMS-2	2552 10
Health Financial Systems C APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/28/2024 8:51 am		
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	1		T			
50. 00 05000 OPERATING ROOM	0. 000000	154, 076		0 1, 388, 001	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	13, 836		0 109, 071	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 277		0 5, 952	0	54.00
58. 00 05800 MRI	0. 000000	0		0 32, 122	0	58. 00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000 0. 000000	6, 314		0 24, 164	0	60. 00 62. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0		0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0.000000	4, 506		0 23, 064	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	4, 300 0		0 23,004	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 584		0 148, 616	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	222, 313		0 543, 040	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	13, 385		0 85, 721	0	73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	
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	Ō	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	·			•		1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
200.00 Total (lines 50 through 199)		422, 291		0 2, 359, 751	0	200. 00

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

Heal th	Financial Systems 0	RTHOPAEDIC HOSPT. AT PARKVIEW			In Lieu of Form CMS-2552-10		
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der CO		Peri od:	Worksheet D	
					rom 01/01/2023		
				7	To 12/31/2023		
			T: +1	e XIX	Hospi tal	5/28/2024 8: 5 ³ PPS	<u>ı am</u>
			11 (1	Charges	поѕрі таі	Costs	
	Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		rait i, coi. 9		Ded. & Coins.	Ded. & Coi ns.		
				(see inst.)	(see inst.)		
		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 OPERATING ROOM	0. 116812	1, 388, 001	(0	162, 135	50.00
53. 00	05300 ANESTHESI OLOGY	0. 137263			0	14, 971	
	05400 RADI OLOGY-DI AGNOSTI C	0. 014113			0	84	1
58. 00	05800 MRI	0. 173497	32, 122		0	5, 573	
60. 00	06000 LABORATORY	0. 186728			o o	4, 512	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	l .		0	ol	62. 30
65. 00	06500 RESPIRATORY THERAPY	0. 000000			0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 345530	23, 064		0	7, 969	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 192446	148, 616		0	28, 601	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262370	543, 040		o	142, 477	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 154519	85, 721		0	13, 246	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	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	(0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000		(0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 053178		(0	0	, 2. 00
200.00	Subtotal (see instructions)		2, 359, 751	(0	379, 568	200. 00
201.00]			(0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		2, 359, 751	(0	379, 568	202. 00

Health Financial Systems	ORTHOPAEDIC HOS	PT. AT PARKVIEW		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider Co	CN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/28/2024 8:5	pared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00

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 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/28/2024 8:5	
	Title XVIII	Hospi tal	PPS	
Cost Contor Doscription			•	

DIRT 1. ALL SPROVIDES CLEARWHATS LEART FIRST DAYS LEART CARRY LEART CARRY LEART DAYS LEART CARRY LEART DAYS			Title XVIII	Hospi tal	PPS	ı allı
INPATENT OWN INPATENT OWN INPATENT OWN Inpatient days (Including private room days and seing-bed days, excluding newborn) 1,210 1,00		Cost Center Description				
Impatient days (including private room days and swing-bed days, excluding nemborn)		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Inpatient days (Including private room days and safing-bed days, excluding newborn) 1,210 1.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00	1.00		s, excluding newborn)		1, 210	1.00
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 1. 160 J. 5. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 7. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 8. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SM Type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SM Type inpatient days applicable to this line) 10. 00 Swing-bed SM Type inpatient days applicable to the Program (excluding swing-bed and 10. 00 Swing-bed SM Type inpatient days applicable to the SM Type inpatient days applicable to service services applicable to service services applicable to service services through December 31 of the cost reporting period in through December 31 of the cost reporting period in the SM Type inpatient days applicable to services after December 31 of the cost reporting period (line 6 S X I I I I I I I I I I I I I I I I I I	2.00				1, 210	
Semi-private room days (excluding swing-bed and observation bed days) through December 31 of the cost of porting partial swing-bed SNF type inpartient days (including private room days) after December 31 of the cost of t	3.00		/s). If you have only pri	vate room days,	0	3. 00
5.00 Total swing-bed SNF type inpatient days (Including private room days) after December 31 of the cost of total swing-bed SNF type inpatient days (Including private room days) after December 31 of the cost operating period (If calendar year, enter 0 on this line) 8.00 Total swing-bed SNF type inpatient days (Including private room days) through December 31 of the cost reporting period (If calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 10.01 SNIng-bed SNF type inpatient days (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 10.02 SNIng-bed SNF type inpatient days applicable to the Program (excluding swing-bed and nextourn days) (see instructions) 11.00 SNing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 12.00 SNing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 13.00 SNing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) 14.00 Medically hecember 31 of the cost reporting period (If calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Navery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost room of the cost reporting period (Including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost room of the cost reporting period (Including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (Including period Reporting period (Including period Reporting peri	4 00		od days)		1 160	4.00
reporting period (if Falendar year, enter 0 and this line) 7. 00 Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if Falendar year, enter 0 and this line) 8. 00 Proporting period (if Falendar year, enter 0 and this line) 9. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (isse instructions) 11. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after through December 31 of the cost reporting period (isse instructions) 12. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 13. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 14. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) 15. 00 Total nursery days (title VIII only VIIII only VIII				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days) including private room days applicable to the Program (excluding swing-bed and newtorn days) including private room days applicable to the Program (excluding swing-bed and newtorn days) including private room days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (including private room days) after 0 page 20 period (see instructions) 11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after 0 period (including private room days)	0.00		adyer till edgi. December	0. 0. 1 0001	· ·	0.00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost lotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Including private room days applicable to the Program (excluding swing-bed and reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and reporting period (see instructions) 8.00 Exercise the cost reporting period (see instructions) 9.00 Exercise the cost reporting period (see instructions) 9.00 Exercis	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Sting-bed SNF type inpatient days applicable to title XVIII only (including private room days) after period (including private room days) (including private room days) after period (including private room days) (includ	7.00			24 6 11		7.00
Total swing-bed NF type inpatient days (Including private room days) arter December 31 of the cost reporting pariod (if calendar year, enter 0 on this line)	7.00		days) through becember	31 of the cost	0	7.00
reporting period (if callendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) through December 31 of the cost reporting period (see instructions) and the private room days after through December 31 of the cost reporting period (see instructions) and through December 31 of the cost reporting period (see instructions) and through December 31 of the cost reporting period (see instructions) and through December 31 of the cost reporting period (see instructions) and through December 31 of the cost reporting period (including private room days) and including a period (see instructions) and the December 31 of the cost reporting period (including year, enter on this line) (see instructions) and the December 31 of the cost reporting period (including year, enter on this line) (see instructions) (se	8.00		n davs) after December 3	of the cost	0	8.00
newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 bing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room daing private room days) 18.00 Medically necessary private room daing private room days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost			,			
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period 14.00 Madi Cally necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Madi Cally necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Marsery days (title V or XIX only) 18.00 Marsery days (title V or XIX only) 18.00 Marsery days (title V or XIX only) 19.00 Marsery days	9.00		the Program (excluding	swi ng-bed and	278	9. 00
through December 31 of the cost reporting period (see instructions) 11.00 Sing-bed SNF type inpatient days applicable to title XV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nursery days (title V or XIX only) 19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost one reporting period (including private room days) 19.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including private room days) 20.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost one reporting period (including private room days) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line one private room days applicable to SNF type services after December 31 of the cost reporting period (line one private room days applicable to SNF type services after December 31 of the cost reporting period (line one private room days applicable to SNF type services after December 31 of the cost reporting period (line one private room days applicable to SNF type services after December 31 of the cost reporting period (line one private room days d	10.00		alv. (i polydina privoto r	nom doug)	0	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x ine 17) NF swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x ine 18) NF swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x ine 18) 19.00 NF swing-bed cost applicable to N	10.00			Juli days)	U	10.00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) RIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,649,950) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine servic	26. 00				0	26. 00
28. 00 29. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 30	27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		8, 649, 950	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00				, ,		
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			and observation bed cha	arges)	-	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32.00 31.00 0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 34.00 32.00 35.00 36.00 36.00 9 36.00 36.00 37.00 General inpatient routine service cost and private room cost differential (line 8, 649, 950) 36.00 37.00 37.00 General inpatient routine service cost and private room cost differential (line 8, 649, 950) 37.00 Frogram general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 39.00 40.00						1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 37.00 37.00 38.00 37.00			- line 28)		-	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 34.00 34.00 35.00 37.00 27 minus line 36) 8, 649, 950 37.00 7, 148.72 38.00 1, 987, 344 39.00	32.00		,			1
35. 00 Average per diem private room cost differential (line 34 x line 31) 0. 00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38. 00 9. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 987, 344 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		, , , , , , , , , , , , , , , , , , , ,				
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 649, 950 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adv. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , ,	le 31)			1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 987, 344 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , ,	and private room cost di	fferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7, 148.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 987, 344 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)]
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 7,148.72 38.00 9,00 Program general inpatient routine service cost (line 9 x line 38) 1,987,344 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,987,344 39.00 40.00	20.00				7 440 70	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
		, ,				1
		, , , , , , , , , , , , , , , , , , , ,	•			1

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-0167	Peri od: From 01/01/2023	Worksheet D-1	
					To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
	0 1 0 1 5 11	T		e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Dav	Average Per SDiem (col. 1		Program Cost (col. 3 x col.	
		impatront oost	patront bay	col . 2)		4)	
12.00	NUDCEDY (+: +1 - V 0 VIV1)	1.00	2. 00	3. 00	4. 00	5. 00	12.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43. 00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description	1		•			
40.00	D					1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)	4, 502, 342	48. 00 48. 01
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				COT CHILIT 1)	6, 489, 686	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	164, 862	50.00
51. 00	Pass through costs applicable to Program inpand IV)		ry services (f	rom Wkst. D, s	sum of Parts II	111, 846	51.00
52.00	Total Program excludable cost (sum of lines		lated '	vol al an !!	antint cod	276, 708	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	erated, non-ph	ysician anestr	netist, and	6, 212, 978	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54.00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor					0.00	
56.00	Target amount (line 54 x sum of lines 55, 55			li F/!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (line 56 minus	11ne 53)	0 1 0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	endi ng 1996,		59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om nrior vear	cost report i	indated by the	0.00	60.00
00.00	market basket)			•			
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operatir	ng costs (line	0	61.00
	enter zero. (see instructions)	00), 01 1 % 01	the target a	mount (Time so	o), otherwise		
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	oer 31 of the	cost reporting	neriod (See	0	65. 00
	instructions)(title XVIII only)				, ,		
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	•		, ,			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	•	n (line 14 x l	i ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•		•			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B, F	art II, column		75. 00
76. 00	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 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi der recon	ds)			78. 00 79. 00
80. 00	Total Program routine service costs for comp	arison to the c			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		/				84. 00
85.00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougn 85)				86. 00
07.00	Total observation bed days (see instructions					50	4

50 87.00 7,148.72 88.00 357,436 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST			·		
90.00 Capital -related cost	717, 569	8, 649, 950	0. 08295	6 357, 436	29, 651	90.00
91.00 Nursing Program cost	0	8, 649, 950	0.00000	0 357, 436	0	91.00
92.00 Allied health cost	0	8, 649, 950	0.00000	0 357, 436	0	92.00
93.00 All other Medical Education	0	8, 649, 950	0. 00000	0 357, 436	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:	Worksheet D-1	2332-10
		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal	572872024 8: 5 PPS	ı aiii
	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 Inpatient days (including private room days, excluding swing-b			1, 210	1. 00 2. 00
2. 00 3. 00	Private room days (excluding private room days, excluding swing-bell private room days (excluding swing-bed and observation bed day		vate room days	1, 210 0	3.00
0.00	do not complete this line.	ο) you have om y μ	vare room daye,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			1, 160	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	m days) through December	31 OF the COST	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	6	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (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 XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of 1	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	often December 21 of th		0.00	20. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	arter becember 31 or tr	le Cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			8, 649, 950	
22. 00	Swing-bed cost applicable to SNF type services through Decembe 5×1 line 17)	r 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	:31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3×1 ine 20)	1 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)		8, 649, 950	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)		3.17	0	29. 00
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	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min		ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	nd neither error and 11 f	Forential (1:	0 (40 050	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	na private room cost dif	rerential (line	8, 649, 950	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			7, 148. 72	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			42, 892	1
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	42, 892	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0167	Peri od: From 01/01/2023	Worksheet D-1	
					To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per sDiem (col. 1		Program Cost (col. 3 x col.	
		Impatrent cost	Ппраттепт рау	col. 2)	-	4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44.00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti	st. D-3, col. 3	3, line 200)	III lino 10	column 1)	84, 314	48. 00 48. 01
	Total Program inpatient costs (sum of lines				COLUMN 1)	127, 206	
	PASS THROUGH COST ADJUSTMENTS]
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	3, 558	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	2, 003	51.00
E2 00	and IV)	EO and E1)				F F/1	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-nh	ysician anesth	netist, and	5, 561 121, 645	
	medical education costs (line 49 minus line	9 1				,]
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						54. 00
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	orting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		om prior year	cost report, ι	updated by the	0.00	60.00
	market basket)					_	
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les					0	61.00
	53) are less than expected costs (lines 54 x						
62. 00	enter zero. (see instructions)					0	(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportino	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(TITIE XVII	i only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost reno	orting period	0	68. 00
00. 00	(line 13 x line 20)	e costs arter i	occomber or or	the cost repo	or tring period	Ĭ	00.00
69. 00	Total title V or XIX swing-bed NF inpatient		•			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c	ost per diem (I		•			71.00
72. 00 73. 00	Program routine service cost (line 9 x line		n (lino 14 v l	ino 2E)			72. 00 73. 00
74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	•		•	Part II, column		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 Total Program routine service costs for comp			,	nus line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost rimitatio	(11116 /0 11111	143 TTHE 77)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 8	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ons)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						4
87. NN	Total observation bed days (see instructions)				50	87.00

50 87.00 7,148.72 88.00 357,436 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	ORTHOPAEDIC HOSE	PT. AT PARKVI EW		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Pre 5/28/2024 8:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	717, 569	8, 649, 950	0. 08295	6 357, 436	29, 651	90.00
91.00 Nursing Program cost	0	8, 649, 950	0.00000	0 357, 436	0	91.00
92.00 Allied health cost	0	8, 649, 950	0.00000	0 357, 436	0	92.00
93.00 All other Medical Education	0	8, 649, 950	0.00000	0 357, 436	l 0	93.00

Heal th F	Financial Systems	ORTHOPAEDI C HOSPT. AT PARKVI EW		In Lie	u of Form CMS-2	2552-10
I NPATI EI	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2023 To 12/31/2023	5/28/2024 8:5	pared:
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			715, 931		30. 00
	NCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 1168			
	05300 ANESTHESI OLOGY		0. 1372		152, 722	53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 0141			
	05800 MRI		0. 1734			58. 00
1	06000 LABORATORY		0. 18672			
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62. 30
	06500 RESPI RATORY THERAPY		0.00000		0	65. 00
	06600 PHYSI CAL THERAPY		0. 34553			
	06900 ELECTROCARDI OLOGY		0.00000		0	69. 00
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1924		-	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2623			
	07300 DRUGS CHARGED TO PATIENTS		0. 1545		123, 799	
1	07697 CARDI AC REHABI LI TATI ON		0.00000		0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 98
	07699 LI THOTRI PSY		0.00000		0	
	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000 0. 00000		0	77. 00 78. 00
	07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0	0	78.00
	DUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0.0000	00	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000		0	
200.00	Total (sum of lines 50 through 94 and	d 06 through 00)	0.0531	23, 582, 931	4, 502, 342	
200.00	Less PBP Clinic Laboratory Services-F			23, 302, 931		200.00
201.00	Net charges (line 200 minus line 201)			23, 582, 931		201.00
202.00	Inct charges (Title 200 millias Title 201)	,	I	23, 302, 731		1202.00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co	CN: 15-0167	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2023		
				To 12/31/2023	5/28/2024 8:5	
		Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	LABORT ENT DOUTLAGE OFFICE OFFICE		1. 00	2. 00	3. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	10.007		
30.00	03000 ADULTS & PEDIATRICS			12, 336		30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0.11/0	12 154, 076	17 000	50. 00
53. 00	05300 ANESTHESI OLOGY		0. 1168° 0. 13726		17, 998 1, 899	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 13720		1, 699	
58. 00	05800 MRI		0. 0141		0	
60.00	06000 LABORATORY		0. 1734		1, 179	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62. 30
65.00	06500 RESPIRATORY THERAPY		0. 00000		0	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 34553		1, 557	66.00
69. 00	06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 19244		1, 267	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 26237	70 222, 313	58, 328	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 15451	19 13, 385	2, 068	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0.00000	00	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.00000	00	0	76. 98
76. 99	07699 LI THOTRI PSY		0.00000	00	0	76. 9
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	78.00
	OUTPATIENT SERVICE COST CENTERS					
90.00			0. 00000		0	
92.00			0. 05317		0	92.00
200.00				422, 291	84, 314	
201.00				0		201. 00
202.00	Net charges (line 200 minus line 201))		422, 291		202. 00

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/28/2024 8:51 am

		5/28/2024 8: 5	1 am
	Title XVIII Hospital	PPS	
		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 prior to October 1 (see	2, 875, 399	1
	instructions)		
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	705, 338	1. 02
	instructions)	_	
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octob	per 0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
1.04	October 1 (see instructions)		1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	103, 032	
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	159, 978	
3.00	Managed Care Simulated Payments	5, 379, 414	1
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	36.86	4. 00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending	on 0.00	5.00
3.00	or before 12/31/1996. (see instructions)	0.00	3.00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap f		1
	new programs in accordance with 42 CFR 413.79(e)		
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 c	of 0.00	6. 26
	the CAA 2021 (see instructions)		
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the second standard of the second standard of the second se	ne 0.00	7. 01
7. 02	cost report straddles July 1, 2011 then see instructions.	0.00	7. 02
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		7.02
	and 87 FR 49075 (August 10, 2022) (see instructions)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
	1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the co	ost 0.00	8. 01
	report straddles July 1, 2011, see instructions.		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
0. 21	instructions)	0.00	0. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0.00	9.00
	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
	FTE count for residents in dental and podiatric programs.	•	11. 00
12. 00	Current year allowable FTE (see instructions)	•	12. 00
13.00	Total allowable FTE count for the prior year.	•	13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 199	7, 0.00	14. 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 (see instructions)	0.00	1
17. 00	Adjustment for residents displaced by program or hospital closure	•	17. 00
18. 00	Adjusted rolling average FTE count	0.00	1
	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000	•
20. 00	Prior year resident to bed ratio (see instructions)	0. 000000	1
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	
22.00	IME payment adjustment (see instructions)	0	22. 00
22. 01	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 cap slots under 42 CFR 412.105	0.00	23. 00
0.4.00	(f)(1)(i v)(C).	0.00	04.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	1
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	1
	IME add-on adjustment amount (see instructions)	0.000000	1
	IME add-on adjustment amount - Managed Care (see instructions)	0	1
29. 00	Total IME payment (sum of lines 22 and 28)	0	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	1
	Disproportionate Share Adjustment		1
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	1
31.00	Percentage of Medicaid patient days (see instructions)	0.00	
32.00	Sum of lines 30 and 31	0.00	1
33.00	Allowable disproportionate share percentage (see instructions)	0.00	1
34. 00	Disproportionate share adjustment (see instructions)	0	34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Peri od: From 01/01/2023	Worksheet E Part A	
			To 12/31/2023	5/28/2024 8: 5 ²	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2. 00	
	Uncompensated Care Payment Adjustment		11.00	2100	
35. 00	Total uncompensated care amount (see instructions)		0	0	35. 0
5. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	•
5. 02	Hospital UCP, including supplemental UCP (see instructions)		0	0	35. (
5. 03	Pro rata share of the hospital UCP, including supplemental UCI	P (see instructions)	0	0	35.
6. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu	0 0 db (46)		36.
0. 00	Total Medicare discharges (see instructions)	scharges (Titles 40 till ou	0		40.
1. 00	Total ESRD Medicare discharges (see instructions)		0		41.
1. 01	Total ESRD Medicare covered and paid discharges (see instruct	ions)	0		41.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.
3. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
F 00	days)		0.00		4.5
5.00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41		0.00		45. 46.
6. 00 7. 00	Subtotal (see instructions)	. 01)	3, 843, 747		40.
8. 00	Hospital specific payments (to be completed by SCH and MDH, si	mall rural hospitals	3, 643, 747		48.
0. 00	only. (see instructions)	ilari Turui 1103pi tura			10.
			•	Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			3, 843, 747	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			287, 348	50. 51.
1. 00 2. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iii			0	52.
3. 00	Nursing and Allied Health Managed Care payment	ne 49 see Tristi ucti oris).		0	53.
4. 00	Special add-on payments for new technologies			Ö	54.
4. 01	Islet isolation add-on payment			0	54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55.
5. 01	Cellular therapy acquisition cost (see instructions)			0	55.
5. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57.
3.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		4 121 005	58.
9. 00 0. 00	Total (sum of amounts on lines 49 through 58)			4, 131, 095 0	59. 60.
1. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	line 60)		4, 131, 095	
2. 00	Deductibles billed to program beneficiaries	11110 00)		225, 074	62.
3. 00	Coinsurance billed to program beneficiaries			0	63.
4. 00	Allowable bad debts (see instructions)			51, 601	i
5. 00	Adjusted reimbursable bad debts (see instructions)			33, 541	65.
5. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 939, 562	
3. 00	Credits received from manufacturers for replaced devices for			0	68.
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(FUI SCH SEE LINSTRUCTION	5)	0	69. 70.
). 00). 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70. 70.
). 30). 75	N95 respirator payment adjustment amount (see instructions)	at on, adjustment (see	instructions)	0	70.
0. 87	Demonstration payment adjustment amount before sequestration			0	70.
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			Ö	
). 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70.
	HSP honus navment HVRP adjustment amount (see instructions)			ا م	70

0 70. 90 0 70. 91 0 70. 92 0 70. 93

0 70. 94 0 70. 95

70. 90 HSP bonus payment HVBP adjustment amount (see instructions)
70. 91 HSP bonus payment HRR adjustment amount (see instructions)
70. 92 Bundled Model 1 discount amount (see instructions)

70.93 | HVBP payment adjustment amount (see instructions)

70. 94 HRR adjustment amount (see instructions) 70. 95 Recovery of accelerated depreciation

			1	o 12/31/2023	Date/Time Pre 5/28/2024 8:5	
		Title	xVIII	Hospi tal	PPS	
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70. 97
70. 98	Low Volume Payment-3	(10/1)		0	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	9 & 70)			3, 939, 562	71.00
71. 01	Sequestration adjustment (see instructions)	ŕ			78, 791	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				4, 019, 941	72. 00
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	73.00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	!, 72, and			-159, 170	74. 00
74 01	73)					74 01
74. 01 75. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordan	oo with			22 1/0	74. 01 75. 00
75.00	CMS Pub. 15-2, chapter 1, §115.2	ice with			32, 160	/5.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		L			1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	of 2.03			0	90.00
	plus 2.04 (see instructions)				_	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	ıcti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	i ons)			0	93.00
94.00	The rate used to calculate the time value of money (see instru	ıcti ons)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruct	i ons)			0	96. 00
				Prior to 10/1		
	HSP Bonus Payment Amount			1. 00	2. 00	
100 00	HSP bonus amount (see instructions)			O	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			٩		100.00
101.00	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101.00
	HVBP adjustment amount for HSP bonus payment (see instructions	;)		0		102. 00
	HRR Adjustment for HSP Bonus Payment	,		<u>'</u>		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)			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adju	stment			
200.00	Is this the first year of the current 5-year demonstration per	iod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement	10)				
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	: 49)				201. 00
	Medicare discharges (see instructions)					202. 00 203. 00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5 year demonst	ration	203.00
	period)	iiist year i	or the current	5-year demonst	.1 a t 1 011	
204 00	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					1
207. 00	Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	,				208. 00
209.00	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					1
	Total adjustment to Medicare Part A IPPS payments (from line 2	11)				
213.00	Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ŕ				213. 00
213.00	Total adjustment to Medicare Part A IPPS payments (from line 2	ŕ	bursement)			212. 00 213. 00 218. 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	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 5/28/2024 8:51 am
	T1 11 100111		222

		Title XVIII	Hospi tal	PPS	1 dili
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			0	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)			13, 935, 876	2. 00
3.00	OPPS or REH payments			13, 099, 033	3. 00
4.00	Outlier payment (see instructions)			30, 252	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	1		0. 000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs including REH direct grad	duate medical educa	ntion costs from	0	9. 00
	Wkst. D, Pt. IV, col. 13, line 200			_	
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11. 00
	Reasonable charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69))		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15 00	Customary charges Aggregate amount actually collected from patients liable for payment	. 6		0	15 00
15. 00 16. 00	Amounts that would have been realized from patients liable for payment		9	0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	ant for services of	i a chargebasi s	O	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if I	ine 18 exceeds lir	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only if I</pre>	ina 11 avcaads lir	na 18) (saa	0	20. 00
20.00	instructions)	The Triexceeds Tri	ie 10) (See	U	20.00
21. 00	Lesser of cost or charges (see instructions)			0	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see instruction	ıs)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			13, 129, 285	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			1, 655, 908	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (f	for CAH, see instru	ıctions)	0	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus th		'	11, 473, 377	27. 00
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, line 50)	1		0	28. 00
28. 50 29. 00	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28. 50 29. 00
30. 00	Subtotal (sum of lines 27, 28, 28.50 and 29)			11, 473, 377	
31.00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)			11, 473, 377	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 53, 675	33. 00 34. 00
	Adjusted reimbursable bad debts (see instructions)			34, 889	
	Allowable bad debts for dual eligible beneficiaries (see instruction	ns)			36. 00
37. 00	Subtotal (see instructions)			11, 508, 266	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Di oneer ACO demonstration navment adjustment (see instructions)			0	39. 00 39. 50
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced dev	vices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			11, 508, 266	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			230, 165 0	40. 01 40. 02
	Sequestration adjustment adjustment amount after sequestration			U	40. 02
	Interim payments			11, 243, 907	41. 00
41. 01	Interim payments-PARHM			•	41. 01
	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			04 404	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			34, 194	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance wit	th CMS Pub. 15-2 c	chapter 1.	0	44. 00
00	§115. 2	5			55
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	
	Time Value of Money (see instructions)				92.00
	1		l l		

Health Financial Systems	ORTHOPAEDIC HOSPT. AT PARKVIEW	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0167	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	pared:
			5/28/2024 8:5	ı am
	Title XVIII	Hospi tal	PPS	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

| Period: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 8:51 am Health Financial Systems ORTHOF ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0167

					5/28/2024 8: 5	1 am
			XVIII	Hospi tal	PPS	
		I npati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 019, 94		11, 243, 907	1. 00
2.00	Interim payments payable on individual bills, either			0	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					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	ABSOSTMENTS TO TROVIDER			Ö		3. 02
3. 03			1	o	0	3. 03
3. 04			l .	o	0	3. 04
3. 05				o	0	3. 05
0.00	Provider to Program		1	<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			o	0	3. 50
3. 51				o	0	3. 51
3.52				o	0	3. 52
3.53				o	0	3. 53
3.54				o	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 019, 94	1	11, 243, 907	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR	ı	1			F 00
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		1	0	1 0	5. 01
5. 02	TENTATIVE TO TROVIDER			Ö		5. 02
5. 03				o	0	5. 03
	Provider to Program		1	-1		
5.50	TENTATI VE TO PROGRAM			o	0	5. 50
5. 51				O	0	5. 51
5. 52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1	0	34, 194	6. 01
6. 02	SETTLEMENT TO PROGRAM		159, 17		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 860, 77		11, 278, 101	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Induite Of COTTL actor	I		1	1	0.00

Heal th	Financial Systems ORTHOPAEDIC HOSPT.	AT PARKVIEW	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0167	Peri od: From 01/01/2023 To 12/31/2023		epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14	1	1. 00
2.00	Medicare days (see instructions)			1	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)			1	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		ı	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I	ı	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			1	8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		1	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)			1	31.00
22 00	Polance due provider (line 0 (or line 10) minus line 20 and l	ing 21) (and instruction)		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

Heal th	Financial Systems ORTHOPA	AEDIC HOSPT.AT PARKVIEW	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0167	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/28/2024 8:51	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line	2, or sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount	(see instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)		0	4.00
5.00	The rate used to calculate the time value of money	(see instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see in	structions)		0	6.00
7. 00	Time value of money for capital related expenses (0	7. 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: | Worksheet G | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 8:51 am

oni y)					5/28/2024 8:5	1 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3, 354, 697		0	0	
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	
4. 00	Accounts receivable	30, 537, 962	1	0	0	
5. 00	Other recei vabl e	0	d	0	Ō	
6.00	Allowances for uncollectible notes and accounts receivable	0	c	0	0	
7.00	Inventory	0	C	0	0	
8.00	Prepai d expenses	49, 555	l .	0	0	
9. 00 10. 00	Other current assets Due from other funds	-7, 304, 580		,	0	
11. 00	Total current assets (sum of lines 1-10)	26, 637, 634		-	1	1
11.00	FIXED ASSETS	20,007,001		,		11.00
12.00	Land	0	C	0	0	12. 00
13.00	Land improvements	0	C	-	1	
14. 00	Accumulated depreciation	0	C	-		1
15. 00 16. 00	Buildings Accumulated depreciation	9, 446, 043	C	1	0	
17. 00	Leasehold improvements	-4, 307, 369	1	-	0	
18. 00	Accumulated depreciation	11, 777, 922	1	1	Ö	
19. 00	Fi xed equipment	-5, 035, 854	1	0	0	
20.00	Accumulated depreciation	219, 429	c	0	0	20.00
21. 00	Automobiles and trucks	-123, 609		1	0	
22. 00	Accumul ated depreciation	21, 045		1	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	-21, 045 60, 051, 312	l .	1	0	
25. 00	Mi nor equi pment depreci abl e	-26, 964, 143		1	0	
26. 00	Accumulated depreciation	0	i c	,	Ö	
27. 00	HIT designated Assets	0) c	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	C	-	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	45, 063, 731	<u> </u>	0	0	30. 00
31. 00	Investments	0		0	0	31.00
32. 00	Deposits on Leases	Ö		-	· -	
33. 00	Due from owners/officers	0) c	0	0	33. 00
34.00	Other assets	54, 944, 896	c	0	0	
35. 00	Total other assets (sum of lines 31-34)	54, 944, 896	1	,	0	1
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	126, 646, 261	<u> </u>	0	0	36. 00
37. 00	Accounts payable	7, 335, 294	1 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	943, 995	1	-	1	
39. 00	Payroll taxes payable	0	d	0	0	
40.00	Notes and Loans payable (short term)	1, 993, 872	C	0	0	
41. 00	Deferred income	0	C	0	0	
42.00	Accel erated payments	0]		_	42.00
43. 00 44. 00	Due to other funds Other current liabilities	3, 286, 689			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	13, 559, 850	1	_		
	LONG TERM LIABILITIES			,		
46. 00	Mortgage payable	0	C	0	0	
47. 00	Notes payable	0	C	-		1
48. 00	Unsecured Loans	0	C	-	1	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	31, 390, 701 31, 390, 701	l .	-	· -	
51. 00	Total liabilities (sum of lines 45 and 50)	44, 950, 551	l .		l	
01.00	CAPI TAL ACCOUNTS	11,700,001		,		1 0 00
52.00	General fund balance	81, 695, 710				52. 00
53. 00	Specific purpose fund		(c)		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 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	81, 695, 710	l .	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	126, 646, 261	[C	0	0	60. 00
	[59]	I	I	1	I	I

19.00

0

0

STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0167 Peri od: Worksheet G-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 8:51 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 79, 094, 423 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 70, 887, 466 2.00 3.00 Total (sum of line 1 and line 2) 149, 981, 889 0 3.00 4.00 Additions (credit adjustments) (specify) 0 0 4.00 5.00 NON ALLOWABLE HOME OFFICE INTEREST E 813, 822 0 5.00 6.00 6.00 0 0 7.00 0 7.00 0 8.00 0 8.00 0 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 813, 822 10.00 150, 795, 711 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 0 12.00 13.00 TRANSFERS 69, 100, 000 13.00 14.00 0 14.00 0 0 0 15.00 0 15.00 16.00 0 0 0 16.00 17.00 0 17.00 69, 100, 000 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 81, 695, 711 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 Additions (credit adjustments) (specify) 4.00 4.00 5.00 NON ALLOWABLE HOME OFFICE INTEREST E 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 TRANSFERS 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00

0

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

			To	12/31/2023	Date/Time Prep 5/28/2024 8:5	
	Cost Center Description		Inpatient	Outpati ent	Total	i diii
	3331 331131 33331 Pt 311		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 364, 480		2, 364, 480	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				0.044.400	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		2, 364, 480		2, 364, 480	10. 00
11 00	Intensive Care Type Inpatient Hospital Services					11 00
11. 00 12. 00	INTENSIVE CARE UNIT					11. 00 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 I	ines	0		0	16. 00
10.00	11-15)	THES	Ö		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		2, 364, 480		2, 364, 480	17. 00
18. 00	Ancillary services		94, 229, 934	479, 969, 780	574, 199, 714	18. 00
19. 00	Outpatient services		0	0	0	19. 00
20.00	RURAL HEALTH CLINIC		0	o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	70, 810, 214	70, 810, 214	
26.00	HOSPI CE					26. 00
27. 00	PPC THERAPY REVENUE		0	27, 321, 631	27, 321, 631	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	96, 594, 414	578, 101, 625	674, 696, 039	28. 00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES			110 1/0 001		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		012 022	118, 160, 891		29. 00
30. 00 31. 00	HOME OFFICE INTREEST EXPENSE		813, 822 0			30. 00 31. 00
32.00			0			32.00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			Ö			35. 00
36. 00	Total additions (sum of lines 30-35)		Ö	813, 822		36. 00
37. 00	DEDUCT (SPECIFY)		0	0.0,022		37. 00
38. 00	525501 (0.25111)		0			38. 00
39. 00			0			39. 00
40.00		j	0			40. 00
41.00			0			41. 00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		118, 974, 713		43.00
	to Wkst. G-3, line 4)					

llool +h	Financial Systems ORTHOPAEDIC HOSPT.	AT DADKVI EW	l m l i a	u of Form CMC 1	DEE2 10
	Financial Systems ORTHOPAEDIC HOSPT. IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0167	Peri od:	u of Form CMS-2 Worksheet G-3	
O I / (I E II	ENT OF REVENUES AND EXPENSES	Trovider con. 10 cier	From 01/01/2023		
			To 12/31/2023	Date/Time Prep 5/28/2024 8:5	
				3/20/2024 0.3	I alli
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		674, 696, 039	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		484, 555, 629	2. 00
3.00	Net patient revenues (line 1 minus line 2)			190, 140, 410	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		118, 974, 713	
5.00	Net income from service to patients (line 3 minus line 4)			71, 165, 697	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			-308, 835	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
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
13. 00 14. 00	Revenue from laundry and linen service			0	
15. 00	Revenue from meals sold to employees and guests			0	15. 00
16. 00	Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to other t	han nationts		0	16. 00
17. 00	Revenue from sale of drugs to other than patients	nan patrents		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
24. 00	OTHER OPERATING INCOME			36, 622	
24. 50	COVI D-19 PHE Funding			0	24. 50
	Total other income (sum of lines 6-24)			-272, 213	
26. 00	Total (line 5 plus line 25)			70, 893, 484	
27. 00	GAIN OF SALE OF ASSET			6, 018	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			6, 018	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			70, 887, 466	29. 00

	Financial Systems ORTHOPAEDIC HOSPT. A ATION OF CAPITAL PAYMENT	Provider CCN: 15-0167	Peri od:	u of Form CMS-2 Worksheet L	2002-10
CALCUL	ATTON OF CAPITAL PATIMENT	Frovider CCN. 15-0107	From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
		T: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11: 4-1	5/28/2024 8: 5 ³	1 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			280, 990	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			6, 358	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructi ons)	3. 18	3. 00
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by the : 1.01)(see instructions)	sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7.00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet E	, part A line	0. 00	7. 00
0.00	30) (see instructions)	4:>		0.00	0 00
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instructions of lines 7 and 8	tions)		0. 00 0. 00	
10.00	Allowable disproportionate share percentage (see instructions)			0.00	
11. 00	Disproportionate share adjustment (see instructions)			0.00	11. 00
12. 00	, , ,			287, 348	
12.00	Total prospective supreur paymente (ess metrastrone)				12.00
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1. 00
	Program inpatient ancillary capital cost (see instructions)				
7 (10)					
2.00				0	2. 00
2. 00 3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
3.00				0	2. 00 3. 00
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0 0 0	2. 00 3. 00 4. 00
3. 00 4. 00	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)			0	2. 00 3. 00 4. 00
3. 00 4. 00 5. 00	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			0 0 0 0	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00	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)	s (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 1. 00 2. 00	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) Program inpatient capital costs for extraordinary circumstances	s (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00
3. 00 4. 00 5. 00	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) Program inpatient capital costs for extraordinary circumstance: Net program inpatient capital costs (line 1 minus line 2)	s (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00	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) Program inpatient capital costs for extraordinary circumstance. Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	s (see instructions)		1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	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) Program inpatient capital costs for extraordinary circumstance: Net program inpatient capital costs (line 1 minus line 2)			1.00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00	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) Program inpatient capital costs for extraordinary circumstance: 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)	tructions)	line 6)	1.00 0 0 0 0 0 0 0.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	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) Program inpatient capital costs for extraordinary circumstances 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 instadjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7)	tructions) circumstances (line 2 x	line 6)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	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) Program inpatient capital costs for extraordinary circumstance: 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 instadjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applications)	tructions) circumstances (line 2 x able)	ŕ	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	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) Program inpatient capital costs for extraordinary circumstances 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 ins Adjustment to capital minimum payment level for extraordinary of Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicator current year comparison of capital minimum payment level to capital minimum payment level t	tructions) circumstances (line 2 x able) pital payments (line 8	less line 9)	1.00 0 0 0 0 0 0 0.00 0 0.00 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	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) Program inpatient capital costs for extraordinary circumstance: 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 instadjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicator current year comparison of capital minimum payment level over capital minimum payment leve	tructions) circumstances (line 2 x able) pital payments (line 8	less line 9)	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	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) Program inpatient capital costs for extraordinary circumstance: 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 ins Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application current year comparison of capital minimum payment level to capital carryover of accumulated capital minimum payment level over capitals.	tructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri	less line 9) or year	0 0 0 0 1.00	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	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) Program inpatient capital costs for extraordinary circumstance: 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 ins Adjustment to capital minimum payment level for extraordinary capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applic. Current year comparison of capital minimum payment level over capurous capital minimum payment level over capurous capital minimum payment level over capurous capital minimum payment level to capital more management level to capital minimum payment level to capital minimum paymen	tructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin	less line 9) or year e 11)	1.00 0 0 0 0 0 0 0.00 0 0.00 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	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) Program inpatient capital costs for extraordinary circumstance: 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 ins Adjustment to capital minimum payment level for extraordinary capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as application current year comparison of capital minimum payment level to capital carryover of accumulated capital minimum payment level over capitals.	tructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri ments (line 10 plus lin the amount on this line	less line 9) or year e 11)	0 0 0 0 0 0 0 0 0.00 0 0.00 0 0 0	2. 00 3. 00 4. 00 5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00

0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)