



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 05/28/2014	TIME: 11:57
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ORTHOPAEDIC HOSPT.AT PARKVIEW (15-0167) ((PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		2,772	16,948	22,805	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF					5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC					10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		2,772	16,948	22,805	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 11119 PARKVIEW PLAZA DRIVE		P.O. BOX:						1	
2	CITY: FORT WAYNE		STATE: IN		ZIP CODE: 46845-1705		COUNTY: ALLEN			
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV-IDER TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ORTHOPAEDIC HOSPT.AT PARKVIEW	15-0167	23060	1	11/08/2007	N	P	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)		FROM: 01 / 01 / 2013		TO: 12 / 31 / 2013					
21	TYPE OF CONTROL (see instructions)		4							
INPATIENT PPS INFORMATION								1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)							N	N	22.01
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE 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.							3	N	23
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.		180							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1					26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1					27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		38	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)							Y	N	39



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N			60
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
	1	2	3	4	
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (see instructions)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. 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)							
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
65							65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010				UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (column 1 divided by (column 1 + column 2)). (see instructions)						66
ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. 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)							
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4))		
	1	2	3	4	5		
67							67
INPATIENT PSYCHIATRIC FACILITY PPS				1	2	3	
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						71
INPATIENT REHABILITATION FACILITY PPS				1	2	3	
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N			75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.						76
LONG TERM CARE HOSPITAL PPS							
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				N		80
TEFRA PROVIDERS							
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.				N		85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.						86



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WORKSHEET S-2  
PART I

TITLE V AND XIX SERVICES		V	XIX		
		1	2		
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90	
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92	
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS		1	2		
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108	
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N			

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, or E only) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98'	N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1			118
		PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	195,073			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N			118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (see instructions). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N		N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N			125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

ALL PROVIDERS		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	15H032	140

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PARKVIEW HEALTH SYSTEM, INC.	CONTRACTOR'S NAME: WISCONSIN PHYSICIANS SERVICE CONTRACTOR'S NUMBER: 8		141
142	STREET: 10501 CORPORATE DRIVE	P.O. BOX: 5600		142
143	CITY: FORT WAYNE	STATE: IN	ZIP CODE: 46895-5600	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	N		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (see CMS Pub. 15-2, section 4020). IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

		TITLE XVIII				
		PART A	PART B	TITLE V	TITLE XIX	
			1	2	3	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N					165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.						166
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			167
168	IF THIS PROVIDER IS A CAH (line 105 is 'Y') AND IS A MEANINGFUL USER (line 167 is 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. (see instructions)				168
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	0.75			169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	10/01/2012	09/30/2013		170



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

## COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	N			4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y		12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N		13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N		14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		15
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
		1	2	3	4
PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS.	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21



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## HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

## COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: ERIC	LAST NAME: NICKESON	TITLE: DIRECTOR, REIMBURSEMENT
42	EMPLOYER: PARKVIEW HEALTH SYSTEM, INC.		
43	PHONE NUMBER: (260) 373-8406	E-MAIL ADDRESS: ERIC.NICKESON@PARKVIEW.COM	







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## HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

## PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	9,810,622	7,558,831	17,369,453	696,032.00	24.95	1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8			4,611,108	4,611,108	173,186.00	26.63	8
9	44						9
10		3,117,995	-696,010	2,421,985	168,266.00	14.39	10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11							11
12							12
13							13
14			5,007,012	5,007,012	177,111.00	28.27	14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17		6,639,336		6,639,336			17
18							18
19		719,537		719,537			19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		986,893	-986,893				26
27		549,409	5,375,991	5,925,400	206,990.00	28.63	27
28							28
29							29
30		121,024	290,914	411,938	16,544.00	24.90	30
31							31
32			294,197	294,197	6,863.00	42.87	32
33							33
34			194,908	194,908	4,547.00	42.87	34
35							35
36							36
37							37
38							38
39			26,011	26,011	607.00	42.85	39
40			12,381	12,381	289.00	42.84	40
41							41
42		140,231	24,255	164,486	6,547.00	25.12	42
43							43

## PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		9,810,622	2,947,723	12,758,345	522,846.00	24.40	1
2	EXCLUDED AREA SALARIES (see instructions)		3,117,995	-696,010	2,421,985	168,266.00	14.39	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		6,692,627	3,643,733	10,336,360	354,580.00	29.15	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)			5,007,012	5,007,012	177,111.00	28.27	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		6,639,336		6,639,336		64.23%	5
6	TOTAL (sum of lines 3 through 5)		13,331,963	8,650,745	21,982,708	531,691.00	41.34	6
7	TOTAL OVERHEAD COST (see instructions)		1,797,557	5,231,764	7,029,321	242,387.00	29.00	7



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## HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

## PART IV - WAGE RELATED COST

## PART A - CORE LIST

		AMOUNT REPORTED	
	<b>RETIREMENT COST</b>		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	391,665	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	1,223,262	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	25,628,684	4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	49,707	7
	<b>HEALTH AND INSURANCE COST</b>		
8	HEALTH INSURANCE (Purchased or Self Funded)	3,274,796	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)	29,477	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	63,377	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	116,334	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-EMPLOYERS PORTION ONLY	1,430,857	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	<b>OTHER</b>		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	31,917	21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	27,944	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	32,268,020	24

## PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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## WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>				
1	WAGE INDEX FISCAL YEAR ENDING DATE	09/30/2014		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2010	12/31/2010	2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH	7/01/2010		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)	1/01/2009		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)	1/01/2012		5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>				
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

## IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE	1/01/2009		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5	1/01/2012		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIB-UTION(S)</b>	11
11.01		02/28/2009	5,000,000	11.01
11.02		04/30/2009	2,500,000	11.02
11.03		05/31/2009	10,000,000	11.03
11.04		10/31/2009	5,000,000	11.04
11.05		01/31/2010	5,000,000	11.05
11.06		02/28/2010	5,300,000	11.06
11.07		07/31/2010	5,000,000	11.07
11.08		10/31/2010	5,000,000	11.08
11.09		03/31/2011	8,600,000	11.09
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)	36		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD	51,400,000		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)	1,427,778		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2	12		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)	17,133,336		16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)	8,495,348		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)	8,495,348		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	25,628,684		19



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## HOSPITAL CONTRACT LABOR AND BENEFIT COST

## WORKSHEET S-3

## PART V - CONTRACT LABOR AND BENEFIT COST

## PART V

## HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



COMPU-MAX

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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

## UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.251302	1
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## MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID		1,155,615	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		37,809	5
6	MEDICAID CHARGES		11,817,354	6
7	MEDICAID COST (line 1 times line 6)		2,969,725	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.		1,776,301	8

## STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP			9
10	STAND-ALONE SCHIP CHARGES			10
11	STAND-ALONE SCHIP COST (line 1 times line 10)			11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.			12

## OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		671,323	13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		3,536,150	14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		888,642	15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		217,319	16

## UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS			18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		1,993,619	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	48,144	299,278	347,422	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	12,099	75,209	87,308	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	11,275	2,739	14,014	22
23	COST OF CHARITY CARE (line 21 minus line 22)	824	72,470	73,294	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?		N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)			25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		3,169,116	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)		31,628	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)		3,137,488	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)		788,457	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)		861,751	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)		2,855,370	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	CAP REL COSTS-BLDG & FIXT		2,285,492	2,285,492	-1,266,758	1,018,734		1,018,734	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,131,685	1,131,685		1,131,685	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	986,893	2,289,924	3,276,817	-986,893	2,289,924	-118,485	2,171,439	4
5	00500	ADMINISTRATIVE & GENERAL	549,409	11,113,822	11,663,231	95,030	11,758,261	6,415,730	18,173,991	5
6	00600	MAINTENANCE & REPAIRS				1,384	1,384		1,384	6
7	00700	OPERATION OF PLANT	121,024	345,604	466,628	20,533	487,161		487,161	7
8	00800	LAUNDRY & LINEN SERVICE								8
9	00900	HOUSEKEEPING		463,522	463,522		463,522		463,522	9
10	01000	DIETARY		194,908	194,908		194,908		194,908	10
11	01100	CAFETERIA								11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION								13
14	01400	CENTRAL SERVICES & SUPPLY		26,180	26,180		26,180		26,180	14
15	01500	PHARMACY		12,381	12,381		12,381		12,381	15
16	01600	MEDICAL RECORDS & LIBRARY								16
17	01700	SOCIAL SERVICE	140,231	18,386	158,617	24,255	182,872		182,872	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	1,556,156	185,581	1,741,737	216,979	1,958,716		1,958,716	30
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	OPERATING ROOM	2,609,731	21,652,510	24,262,241	-18,634,908	5,627,333		5,627,333	50
53	05300	ANESTHESIOLOGY	142,747	1,462	144,209	1,189,428	1,333,637		1,333,637	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,112	382,586	383,698	186	383,884		383,884	54
60	06000	LABORATORY		339,015	339,015		339,015		339,015	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		51,005	51,005		51,005		51,005	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY		68,844	68,844		68,844		68,844	65
66	06600	PHYSICAL THERAPY	523,438	9,507	532,945	90,537	623,482		623,482	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				2,323,642	2,323,642		2,323,642	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				15,649,123	15,649,123		15,649,123	72
73	07300	DRUGS CHARGED TO PATIENTS	61,886	1,192,838	1,254,724	10,704	1,265,428		1,265,428	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
		<b>SPECIAL PURPOSE COST CENTERS</b>								
115	11500	AMBULATORY SURGICAL CENTER (D.P.)	3,117,995	11,202,151	14,320,146	135,073	14,455,219		14,455,219	115
200		TOTAL (sum of lines 118-199)	9,810,622	51,835,718	61,646,340		61,646,340	6,297,245	67,943,585	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	BUILDING DEPRECIATON	A	CAP REL COSTS-MVBLE EQUIP	2		1,131,685	1
2			AMBULATORY SURGICAL CENTER (D	115		135,073	2
500	TOTAL RECLASSIFICATIONS					1,266,758	500
	CODE LETTER - A						
1	MED AND IV SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		17,972,765	1
2							2
500	TOTAL RECLASSIFICATIONS					17,972,765	500
	CODE LETTER - B						
1	TELEPHONE EXPENSE	C	MAINTENANCE & REPAIRS	6		1,384	1
2							2
500	TOTAL RECLASSIFICATIONS					1,384	500
	CODE LETTER - C						
1	PTO PAID	D	ADMINISTRATIVE & GENERAL	5	3,297		1
2			OPERATION OF PLANT	7	726		2
3			SOCIAL SERVICE	17	841		3
4			ADULTS & PEDIATRICS	30	9,337		4
5			OPERATING ROOM	50	15,659		5
6			ANESTHESIOLOGY	53	857		6
7			PHYSICAL THERAPY	66	3,141		7
8			DRUGS CHARGED TO PATIENTS	73	371		8
500	TOTAL RECLASSIFICATIONS				34,229		500
	CODE LETTER - D						
1	PTO EARNED	E	ADMINISTRATIVE & GENERAL	5	91,733		1
2			OPERATION OF PLANT	7	20,207		2
3			SOCIAL SERVICE	17	23,414		3
4			ADULTS & PEDIATRICS	30	259,825		4
5			OPERATING ROOM	50	435,736		5
6			ANESTHESIOLOGY	53	23,834		6
7			PHYSICAL THERAPY	66	87,396		7
8			DRUGS CHARGED TO PATIENTS	73	10,333		8
9			RADIOLOGY-DIAGNOSTIC	54	186		9
500	TOTAL RECLASSIFICATIONS				952,664		500
	CODE LETTER - E						
1	HOME OFFICE	F	ADMINISTRATIVE & GENERAL	5	4,611,108		1
500	TOTAL RECLASSIFICATIONS				4,611,108		500
	CODE LETTER - F						
1	PURCHASED SERVICES	H	ADMINISTRATIVE & GENERAL	5	669,853		1
2			OPERATION OF PLANT	7	269,981		2
3			HOUSEKEEPING	9	294,197		3
4			DIETARY	10	194,908		4
5			CENTRAL SERVICES & SUPPLY	14	26,011		5
6			PHARMACY	15	12,381		6
7			ADULTS & PEDIATRICS	30	17,550		7
8			OPERATING ROOM	50	854,330		8
9			RADIOLOGY-DIAGNOSTIC	54	371,986		9
10			LABORATORY	60	339,015		10
11			RESPIRATORY THERAPY	65	69,613		11
12			PHYSICAL THERAPY	66	415		12
13			DRUGS CHARGED TO PATIENTS	73	523,493		13
14			AMBULATORY SURGICAL CENTER (D	115	23,527		14
500	TOTAL RECLASSIFICATIONS				3,667,260		500
	CODE LETTER - H						
1	IMPLANTS	I	IMPL. DEV. CHARGED TO PATIENT	72		15,649,123	1
500	TOTAL RECLASSIFICATIONS					15,649,123	500
	CODE LETTER - I						
1	ANESTHESIA	J	ANESTHESIOLOGY	53		1,164,737	1
500	TOTAL RECLASSIFICATIONS					1,164,737	500
	CODE LETTER - J						
1	ASC BENEFITS	K	AMBULATORY SURGICAL CENTER (D	115		719,537	1
500	TOTAL RECLASSIFICATIONS					719,537	500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				9,265,261	36,774,304	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
		COST CENTER	LINE #	SALARY	OTHER	
	1	2	3	4	5	



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	BUILDING DEPRECIATON	A	CAP REL COSTS-BLDG & FIXT	1		1,266,758	9	
2							10	
500	TOTAL RECLASSIFICATIONS CODE LETTER - A					1,266,758	500	
1	MED AND IV SUPPLIES	B	ADULTS & PEDIATRICS	30		52,183	1	
2			OPERATING ROOM	50		17,920,582	2	
500	TOTAL RECLASSIFICATIONS CODE LETTER - B					17,972,765	500	
1	TELEPHONE EXPENSE	C	OPERATION OF PLANT	7		400	1	
2			OPERATING ROOM	50		984	2	
500	TOTAL RECLASSIFICATIONS CODE LETTER - C					1,384	500	
1	PTO PAID	D	EMPLOYEE BENEFITS DEPARTMENT	4	34,229		1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
500	TOTAL RECLASSIFICATIONS CODE LETTER - D				34,229		500	
1	PTO EARNED	E	EMPLOYEE BENEFITS DEPARTMENT	4	952,664		1	
2							2	
3							3	
4							4	
5							5	
6							6	
7							7	
8							8	
9							9	
500	TOTAL RECLASSIFICATIONS CODE LETTER - E				952,664		500	
1	HOME OFFICE	F	ADMINISTRATIVE & GENERAL	5		4,611,108	1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - F					4,611,108	500	
1	PURCHASED SERVICES	H	ADMINISTRATIVE & GENERAL	5		669,853	1	
2			OPERATION OF PLANT	7		269,981	2	
3			HOUSEKEEPING	9		294,197	3	
4			DIETARY	10		194,908	4	
5			CENTRAL SERVICES & SUPPLY	14		26,011	5	
6			PHARMACY	15		12,381	6	
7			ADULTS & PEDIATRICS	30		17,550	7	
8			OPERATING ROOM	50		854,330	8	
9			RADIOLOGY-DIAGNOSTIC	54		371,986	9	
10			LABORATORY	60		339,015	10	
11			RESPIRATORY THERAPY	65		69,613	11	
12			PHYSICAL THERAPY	66		415	12	
13			DRUGS CHARGED TO PATIENTS	73		523,493	13	
14			AMBULATORY SURGICAL CENTER (D)	115		23,527	14	
500	TOTAL RECLASSIFICATIONS CODE LETTER - H					3,667,260	500	
1	IMPLANTS	I	MEDICAL SUPPLIES CHARGED TO P	71		15,649,123	1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - I					15,649,123	500	
1	ANESTHESIA	J	OPERATING ROOM	50		1,164,737	1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - J					1,164,737	500	
1	ASC BENEFITS	K	AMBULATORY SURGICAL CENTER (D)	115	719,537		1	
500	TOTAL RECLASSIFICATIONS CODE LETTER - K				719,537		500	
	GRAND TOTAL (DECREASES)				1,706,430	44,333,135		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.



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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.
			COST CENTER	LINE #	SALARY	OTHER	
		1	6	7	8	9	10

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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## RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
PARTS I, II & III

## PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	10,551,305	-1,105,262		-1,105,262		9,446,043		3
4	BUILDING IMPROVEMENTS	1,361,567	143,726		143,726		1,505,293		4
5	FIXED EQUIPMENT	7,863,157	923,105		923,105		8,786,262		5
6	MOVABLE EQUIPMENT	7,940,780	884,168		884,168	390,376	8,434,572		6
7	HIT DESIGNATED ASSETS	1,151,176	1,214,969		1,214,969		2,366,145		7
8	SUBTOTAL (sum of lines 1-7)	28,867,985	2,060,706		2,060,706	390,376	30,538,315		8
9	RECONCILING ITEMS	37,206	-414,873		-414,873		-377,667		9
10	TOTAL (line 7 minus line 9)	28,830,779	2,475,579		2,475,579	390,376	30,915,982		10

## PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	2,285,492							2,285,492	1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (sum of lines 1-2)	2,285,492							2,285,492	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

\* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

## PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	19,737,598		19,737,598	0.661044					1
2	CAP REL COSTS-MVBLE EQU	10,800,717	680,083	10,120,634	0.338956					2
3	TOTAL (sum of lines 1-2)	30,538,315	680,083	29,858,232	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	1,018,734							1,018,734	1
2	CAP REL COSTS-MVBLE EQUIP	1,131,685							1,131,685	2
3	TOTAL (sum of lines 1-2)	2,150,419							2,150,419	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	6,415,607			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS					14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	OTHER OPERATING REVENUE	B	156	ADMINISTRATIVE & GENERAL	5	33
34	OTHER OPERATING REVENUE	B	-33	ADMINISTRATIVE & GENERAL	5	34
35	SELF INSURANCE OFFSET	A	-118,485	EMPLOYEE BENEFITS DEPARTMENT	4	35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		6,297,245			50

- (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.



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## STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

**A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS  
OR CLAIMED HOME OFFICE COSTS:**

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	9,362,936	5,263,882	4,099,054		1
2	5	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	2,316,553		2,316,553	9	2
3								3
4								4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12			11,679,489	5,263,882	6,415,607		5

\* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

**B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B			PARKVIEW HEALTH SYSTEM, INC	60.00	HEALTH SYSTEM	6
7	B			NORTHEAST ORTHOPAEDIC HOSPITAL	40.00	ORTHOPAEDIC SERVICES	7
8							8
9							9
10							10

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:









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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX:  OCCUPATIONAL       PHYSICAL       RESPIRATORY       SPEECH PATHOLOGY

**PART V - OVERTIME COMPUTATION**

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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## REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [XX] RESPIRATORY [ ] SPEECH PATHOLOGY

## PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

## PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65





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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

CHECK APPLICABLE BOX: [ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	1,018,734	1,018,734					1
2	CAP REL COSTS-MVBLE EQUIP	1,131,685		1,131,685				2
4	EMPLOYEE BENEFITS DEPARTMENT	2,171,439			2,171,439			4
5	ADMINISTRATIVE & GENERAL	18,173,991	234,672	27,347	740,762	19,176,772	19,176,772	5
6	MAINTENANCE & REPAIRS	1,384				1,384	544	6
7	OPERATION OF PLANT	487,161		510	51,498	539,169	212,020	7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	463,522		1,461	36,779	501,762	197,310	9
10	DIETARY	194,908		8,166	24,366	227,440	89,437	10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	26,180			3,252	29,432	11,574	14
15	PHARMACY	12,381			1,548	13,929	5,477	15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE	182,872			20,563	203,435	79,998	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	1,958,716	291,300	203,431	230,386	2,683,833	1,055,374	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	5,627,333	456,785	888,412	489,491	7,462,021	2,934,320	50
53	ANESTHESIOLOGY	1,333,637			20,932	1,354,569	532,663	53
54	RADIOLOGY-DIAGNOSTIC	383,884	20,338		46,666	450,888	177,304	54
60	LABORATORY	339,015			42,382	381,397	149,978	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	51,005				51,005	20,057	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	68,844			8,703	77,547	30,494	65
66	PHYSICAL THERAPY	623,482	15,639	2,358	76,808	718,287	282,455	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,323,642				2,323,642	913,735	71
72	IMPL. DEV. CHARGED TO PATIENTS	15,649,123				15,649,123	6,153,770	72
73	DRUGS CHARGED TO PATIENTS	1,265,428			74,519	1,339,947	526,913	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)	14,455,219			302,784	14,758,003	5,803,349	115
118	SUBTOTALS (sum of lines 1-117)	67,943,585	1,018,734	1,131,685	2,171,439	67,943,585	19,176,772	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	67,943,585	1,018,734	1,131,685	2,171,439	67,943,585	19,176,772	202



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT FIXTURES 7	HOUSE-KEEPING EQUIPMENT 9	DIETARY BENEFITS DEPARTMENT 10	CENTRAL SERVICES & SUPPLY 14	PHARMACY TRATIVE & GENERAL 15	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS	1,928						6
7	OPERATION OF PLANT		751,189					7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING			699,072				9
10	DIETARY				316,877			10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY					41,006		14
15	PHARMACY						19,406	15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	716	279,087	259,724	316,877			30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	1,124	437,634	407,271				50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	50	19,485	18,134				54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY	38	14,983	13,943				66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS					41,006		72
73	DRUGS CHARGED TO PATIENTS						19,406	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)							115
118	SUBTOTALS (sum of lines 1-117)	1,928	751,189	699,072	316,877	41,006	19,406	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,928	751,189	699,072	316,877	41,006	19,406	202



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE REPAIRS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	24	25	26		
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE	283,433					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	283,433	4,879,044		4,879,044		30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM		11,242,370		11,242,370		50
53	ANESTHESIOLOGY		1,887,232		1,887,232		53
54	RADIOLOGY-DIAGNOSTIC		665,861		665,861		54
60	LABORATORY		531,375		531,375		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		71,062		71,062		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		108,041		108,041		65
66	PHYSICAL THERAPY		1,029,706		1,029,706		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,237,377		3,237,377		71
72	IMPL. DEV. CHARGED TO PATIENTS		21,843,899		21,843,899		72
73	DRUGS CHARGED TO PATIENTS		1,886,266		1,886,266		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
115	AMBULATORY SURGICAL CENTER (D.P.)		20,561,352		20,561,352		115
118	SUBTOTALS (sum of lines 1-117)	283,433	67,943,585		67,943,585		118
	<b>NONREIMBURSABLE COST CENTERS</b>						
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	283,433	67,943,585		67,943,585		202



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		0	1	2	2A	5	6	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	2,316,553	234,672	27,347	2,578,572	2,578,572		5
6	MAINTENANCE & REPAIRS					73	73	6
7	OPERATION OF PLANT			510	510	28,509		7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING			1,461	1,461	26,531		9
10	DIETARY			8,166	8,166	12,026		10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY					1,556		14
15	PHARMACY					737		15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE					10,757		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		291,300	203,431	494,731	141,910	27	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM		456,785	888,412	1,345,197	394,562	43	50
53	ANESTHESIOLOGY					71,624		53
54	RADIOLOGY-DIAGNOSTIC		20,338		20,338	23,841	2	54
60	LABORATORY					20,167		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS					2,697		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY					4,100		65
66	PHYSICAL THERAPY		15,639	2,358	17,997	37,980	1	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					122,865		71
72	IMPL. DEV. CHARGED TO PATIENTS					827,442		72
73	DRUGS CHARGED TO PATIENTS					70,851		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)					780,344		115
118	SUBTOTALS (sum of lines 1-117)	2,316,553	1,018,734	1,131,685	4,466,972	2,578,572	73	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,316,553	1,018,734	1,131,685	4,466,972	2,578,572	73	202



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT COSTS 7	HOUSE- KEEPING FIXTURES 9	DIETARY MOVABLE EQUIPMENT 10	CENTRAL SERVICES & SUPPLY 14	PHARMACY TRATIVE & GENERAL 15	SOCIAL SERVICE REPAIRS 17	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	29,019						7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		27,992					9
10	DIETARY			20,192				10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY				1,556			14
15	PHARMACY					737		15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE						10,757	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	10,781	10,400	20,192			10,757	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	16,906	16,308					50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	753	726					54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY	579	558					66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS				1,556			72
73	DRUGS CHARGED TO PATIENTS					737		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)							115
118	SUBTOTALS (sum of lines 1-117)	29,019	27,992	20,192	1,556	737	10,757	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	29,019	27,992	20,192	1,556	737	10,757	202



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		24	25	26			
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	688,798		688,798			30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	1,773,016		1,773,016			50
53	ANESTHESIOLOGY	71,624		71,624			53
54	RADIOLOGY-DIAGNOSTIC	45,660		45,660			54
60	LABORATORY	20,167		20,167			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,697		2,697			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,100		4,100			65
66	PHYSICAL THERAPY	57,115		57,115			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,865		122,865			71
72	IMPL. DEV. CHARGED TO PATIENTS	828,998		828,998			72
73	DRUGS CHARGED TO PATIENTS	71,588		71,588			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
115	AMBULATORY SURGICAL CENTER (D.P.)	780,344		780,344			115
118	SUBTOTALS (sum of lines 1-117)	4,466,972		4,466,972			118
	<b>NONREIMBURSABLE COST CENTERS</b>						
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	4,466,972		4,466,972			202



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## COST ALLOCATION - STATISTICAL BASIS

## WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
		1	2	4	5A	5	6	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	78,040						1
2	CAP REL COSTS-MVBLE EQUIP		645,929					2
4	EMPLOYEE BENEFITS DEPARTMENT			17,369,453				4
5	ADMINISTRATIVE & GENERAL	17,977	15,609	5,925,400	-19,176,772	48,766,813		5
6	MAINTENANCE & REPAIRS					1,384	60,063	6
7	OPERATION OF PLANT		291	411,938		539,169		7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		834	294,197		501,762		9
10	DIETARY		4,661	194,908		227,440		10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY			26,011		29,432		14
15	PHARMACY			12,381		13,929		15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE			164,486		203,435		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	22,315	116,112	1,842,868		2,683,833	22,315	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	34,992	507,076	3,915,456		7,462,021	34,992	50
53	ANESTHESIOLOGY			167,438		1,354,569		53
54	RADIOLOGY-DIAGNOSTIC	1,558		373,284		450,888	1,558	54
60	LABORATORY			339,015		381,397		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS					51,005		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY			69,613		77,547		65
66	PHYSICAL THERAPY	1,198	1,346	614,390		718,287	1,198	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					2,323,642		71
72	IMPL. DEV. CHARGED TO PATIENTS					15,649,123		72
73	DRUGS CHARGED TO PATIENTS			596,083		1,339,947		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)			2,421,985		14,758,003		115
118	SUBTOTALS (sum of lines 1-117)	78,040	645,929	17,369,453	-19,176,772	48,766,813	60,063	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,018,734	1,131,685	2,171,439		19,176,772	1,928	202
203	UNIT COST MULT-WS B PT I	13.053998	1.752027	0.125015		0.393234	0.032100	203
204	COST TO BE ALLOC PER B PT II					2,578,572	73	204
205	UNIT COST MULT-WS B PT II					0.052876	0.001215	205



## COMPU-MAX

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## COST ALLOCATION - STATISTICAL BASIS

## WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT FIXTURES SQUARE FEET	HOUSE- KEEPING EQUIPMENT SQUARE FEET	DIETARY BENEFITS DEPARTMENT MEALS SERVED	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY TRATIVE & GENERAL COSTED REQUIS.	SOCIAL SERVICE REPAIRS TIME SPENT	
		7	9	10	14	15	17	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	60,063						7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING		60,063					9
10	DIETARY			27,844				10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY				16,391,396			14
15	PHARMACY					10,000		15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE						10,000	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	22,315	22,315	27,844			10,000	30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	34,992	34,992					50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,558	1,558					54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY	1,198	1,198					66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS				16,391,396			72
73	DRUGS CHARGED TO PATIENTS					10,000		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)							115
118	SUBTOTALS (sum of lines 1-117)	60,063	60,063	27,844	16,391,396	10,000	10,000	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	751,189	699,072	316,877	41,006	19,406	283,433	202
203	UNIT COST MULT-WS B PT I	12.506685	11.638979	11.380441	0.002502	1.940600	28.343300	203
204	COST TO BE ALLOC PER B PT II	29,019	27,992	20,192	1,556	737	10,757	204
205	UNIT COST MULT-WS B PT II	0.483143	0.466044	0.725183	0.000095	0.073700	1.075700	205



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
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	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS							30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
	<b>SPECIAL PURPOSE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)							115
118	SUBTOTALS (sum of lines 1-117)							118
	<b>NONREIMBURSABLE COST CENTERS</b>							
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	4,879,044		4,879,044		4,879,044	30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	11,242,370		11,242,370		11,242,370	50
53	ANESTHESIOLOGY	1,887,232		1,887,232		1,887,232	53
54	RADIOLOGY-DIAGNOSTIC	665,861		665,861		665,861	54
60	LABORATORY	531,375		531,375		531,375	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	71,062		71,062		71,062	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	108,041		108,041		108,041	65
66	PHYSICAL THERAPY	1,029,706		1,029,706		1,029,706	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,237,377		3,237,377		3,237,377	71
72	IMPL. DEV. CHARGED TO PATIENTS	21,843,899		21,843,899		21,843,899	72
73	DRUGS CHARGED TO PATIENTS	1,886,266		1,886,266		1,886,266	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)	239,923		239,923		239,923	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
115	AMBULATORY SURGICAL CENTER (D.P.)	20,561,352		20,561,352		20,561,352	115
200	SUBTOTAL (SEE INSTRUCTIONS)	68,183,508		68,183,508		68,183,508	200
201	LESS OBSERVATION BEDS	239,923		239,923		239,923	201
202	TOTAL (SEE INSTRUCTIONS)	67,943,585		67,943,585		67,943,585	202



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	6,509,297		6,509,297				30
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	43,326,356	39,182,568	82,508,924	0.136256	0.136256	0.136256	50
53	ANESTHESIOLOGY	3,142,651	3,024,309	6,166,960	0.306023	0.306023	0.306023	53
54	RADIOLOGY-DIAGNOSTIC	795,145	945,810	1,740,955	0.382469	0.382469	0.382469	54
60	LABORATORY	1,051,820	229,426	1,281,246	0.414733	0.414733	0.414733	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	215,016	10,000	225,016	0.315809	0.315809	0.315809	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	506,015	108,624	614,639	0.175780	0.175780	0.175780	65
66	PHYSICAL THERAPY	2,827,821	32,777	2,860,598	0.359962	0.359962	0.359962	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,624,983	3,123,832	9,748,815	0.332079	0.332079	0.332079	71
72	IMPL. DEV. CHARGED TO PATIENTS	81,987,467	16,075,283	98,062,750	0.222754	0.222754	0.222754	72
73	DRUGS CHARGED TO PATIENTS	7,184,622	2,898,127	10,082,749	0.187079	0.187079	0.187079	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)	5,703	267,679	273,382	0.877611	0.877611	0.877611	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
115	AMBULATORY SURGICAL CENTER (D.P.)		50,290,457	50,290,457				115
200	SUBTOTAL (SEE INSTRUCTIONS)	154,176,896	116,188,892	270,365,788				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	154,176,896	116,188,892	270,365,788				202



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	INPATIENT ROUTINE SERV COST CENTERS	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	688,798		688,798	5,206	132.31	1,669	220,825	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	688,798		688,798	5,206		1,669	220,825	200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART II

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	1,773,016	82,508,924	0.021489	13,419,553	288,373	50
53	ANESTHESIOLOGY	71,624	6,166,960	0.011614	1,057,984	12,287	53
54	RADIOLOGY-DIAGNOSTIC	45,660	1,740,955	0.026227	259,891	6,816	54
60	LABORATORY	20,167	1,281,246	0.015740	395,868	6,231	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,697	225,016	0.011986	97,567	1,169	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,100	614,639	0.006671	239,646	1,599	65
66	PHYSICAL THERAPY	57,115	2,860,598	0.019966	894,470	17,859	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,865	9,748,815	0.012603	1,923,516	24,242	71
72	IMPL. DEV. CHARGED TO PATIENTS	828,998	98,062,750	0.008454	25,510,988	215,670	72
73	DRUGS CHARGED TO PATIENTS	71,588	10,082,749	0.007100	2,252,311	15,991	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)	33,871	273,382	0.123896			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	3,031,701	213,566,034		46,051,794	590,237	200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	5,206		1,669		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	5,206		1,669		200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART IV

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	82,508,924			13,419,553		6,089,151		50
53	ANESTHESIOLOGY	6,166,960			1,057,984		634,891		53
54	RADIOLOGY-DIAGNOSTIC	1,740,955			259,891		93,774		54
60	LABORATORY	1,281,246			395,868		4,902		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	225,016			97,567		1,805		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	614,639			239,646		9,325		65
66	PHYSICAL THERAPY	2,860,598			894,470				66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,748,815			1,923,516		968,297		71
72	IMPL. DEV. CHARGED TO PATIENTS	98,062,750			25,510,988		1,572,881		72
73	DRUGS CHARGED TO PATIENTS	10,082,749			2,252,311		626,408		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	OBSERVATION BEDS (NON-DISTINCT PART)	273,382					1,127		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	TOTAL (sum of lines 50-199)	213,566,034			46,051,794		10,002,561		200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART V

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	0.136256	6,089,151			829,683			50
53	ANESTHESIOLOGY	0.306023	634,891			194,291			53
54	RADIOLOGY-DIAGNOSTIC	0.382469	93,774			35,866			54
60	LABORATORY	0.414733	4,902			2,033			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315809	1,805			570			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.175780	9,325			1,639			65
66	PHYSICAL THERAPY	0.359962							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332079	968,297			321,551			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.222754	1,572,881			350,366			72
73	DRUGS CHARGED TO PATIENTS	0.187079	626,408			117,188			73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.877611	1,127			989			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)		10,002,561			1,854,176			200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		10,002,561			1,854,176			202

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>	1	2	3	4	5	6	7	
30	ADULTS & PEDIATRICS (General Routine Care)	688,798		688,798	5,206	132.31	180	23,816	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	688,798		688,798	5,206		180	23,816	200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART II

CHECK [ ] TITLE V [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [XX] TITLE XIX [ ] IRF

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 ÷ col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	1,773,016	82,508,924	0.021489	1,739,623	37,383	50
53	ANESTHESIOLOGY	71,624	6,166,960	0.011614	159,020	1,847	53
54	RADIOLOGY-DIAGNOSTIC	45,660	1,740,955	0.026227	33,972	891	54
60	LABORATORY	20,167	1,281,246	0.015740	39,735	625	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,697	225,016	0.011986	2,490	30	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,100	614,639	0.006671	28,830	192	65
66	PHYSICAL THERAPY	57,115	2,860,598	0.019966	102,817	2,053	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	122,865	9,748,815	0.012603	308,071	3,883	71
72	IMPL. DEV. CHARGED TO PATIENTS	828,998	98,062,750	0.008454	3,487,098	29,480	72
73	DRUGS CHARGED TO PATIENTS	71,588	10,082,749	0.007100	331,401	2,353	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)	33,871	273,382	0.123896			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	3,031,701	213,566,034		6,233,057	78,737	200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	5,206		180		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY					43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	5,206		180		200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART IV

CHECK  TITLE V  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	82,508,924			1,739,623				50
53	ANESTHESIOLOGY	6,166,960			159,020				53
54	RADIOLOGY-DIAGNOSTIC	1,740,955			33,972				54
60	LABORATORY	1,281,246			39,735				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	225,016			2,490				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	614,639			28,830				65
66	PHYSICAL THERAPY	2,860,598			102,817				66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,748,815			308,071				71
72	IMPL. DEV. CHARGED TO PATIENTS	98,062,750			3,487,098				72
73	DRUGS CHARGED TO PATIENTS	10,082,749			331,401				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
92	OBSERVATION BEDS (NON-DISTINCT PART)	273,382							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	TOTAL (sum of lines 50-199)	213,566,034			6,233,057				200

(A) Worksheet A line numbers



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-0167

WORKSHEET D  
PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] SWING BED SNF  
 APPLICABLE [ ] TITLE XVIII, PART B [ ] IPF [ ] SNF [ ] SWING BED NF  
 BOXES: [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	0.136256		6,205.082			845,480	50
53	ANESTHESIOLOGY	0.306023		454,404			139,058	53
54	RADIOLOGY-DIAGNOSTIC	0.382469		86,081			32,923	54
60	LABORATORY	0.414733		22,155			9,188	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315809						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.175780		9,220			1,621	65
66	PHYSICAL THERAPY	0.359962		6,518			2,346	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332079		882,173			292,951	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.222754		1,353,401			301,475	72
73	DRUGS CHARGED TO PATIENTS	0.187079		472,970			88,483	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.877611		385			338	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)			9,492,389			1,713,863	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			9,492,389			1,713,863	202

(A) Worksheet A line numbers



## COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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## COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PART I

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

## PART I - ALL PROVIDER COMPONENTS

## INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,206	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,206	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,950	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,669	9
10	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)		10
11	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)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	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 (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,879,044	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,879,044	27

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,879,044	37



COMPU-MAX

ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [ ] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)						937.20	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						1,564,187	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)							40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)						1,564,187	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)		
		1	2	3	4	5		
42	NURSERY (Titles V and XIX only)							42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>							
43	INTENSIVE CARE UNIT							43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47
							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						9,553,549	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						11,117,736	49
<b>PASS-THROUGH COST ADJUSTMENTS</b>								
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						220,825	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						590,237	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						811,062	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						10,306,674	53
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>								
54	PROGRAM DISCHARGES							54
55	TARGET AMOUNT PER DISCHARGE							55
56	TARGET AMOUNT (line 54 x line 55)							56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)							57
58	BONUS PAYMENT (see instructions)							58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET							59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET							60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)							61
62	RELIEF PAYMENT (see instructions)							62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)							63
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>								
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)							64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)							65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)							66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)							67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)							68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)							69



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					256	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					937.20	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					239,923	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	688,798	4,879,044	0.141175	239,923	33,871	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PART I

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [XX] TITLE XIX - I/P [ ] IRF [ ] NF [ ] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	5,206	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	5,206	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	4,950	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	180	9
10	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)		10
11	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)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	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 (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,879,044	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,879,044	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	4,879,044	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [ ] TITLE XVIII, PART A [ ] IPF [ ] TEFRA  
 BOXES: [XX] TITLE XIX - I/P [ ] IRF [ ] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					937.20	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					168,696	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					168,696	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					1,299,101	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,467,797	49
	<b>PASS-THROUGH COST ADJUSTMENTS</b>						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					23,816	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					78,737	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					102,553	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					1,365,244	53
	<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-0167

WORKSHEET D-1  
PARTS III & IV

CHECK  TITLE V - I/P  HOSPITAL  SUB (OTHER)  ICF/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX - I/P  IRF  NF  OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					256	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0167

WORKSHEET D-3

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		2,036,167		30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.136256	13,419,553	1,828,495	50
53	ANESTHESIOLOGY	0.306023	1,057,984	323,767	53
54	RADIOLOGY-DIAGNOSTIC	0.382469	259,891	99,400	54
60	LABORATORY	0.414733	395,868	164,180	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315809	97,567	30,813	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.175780	239,646	42,125	65
66	PHYSICAL THERAPY	0.359962	894,470	321,975	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332079	1,923,516	638,759	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.222754	25,510,988	5,682,675	72
73	DRUGS CHARGED TO PATIENTS	0.187079	2,252,311	421,360	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.877611			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		46,051,794	9,553,549	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		46,051,794		202

(A) Worksheet A line numbers



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-0167

WORKSHEET D-3

CHECK  TITLE V - O/P  HOSPITAL  SUB (OTHER)  SWING BED SNF  PPS  
 APPLICABLE  TITLE XVIII, PART B  IPF  SNF  SWING BED NF  TEFRA  
 BOXES:  TITLE XIX - O/P  IRF  NF  ICF/MR  OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		220,340		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.136256	1,739,623	237,034	50
53	ANESTHESIOLOGY	0.306023	159,020	48,664	53
54	RADIOLOGY-DIAGNOSTIC	0.382469	33,972	12,993	54
60	LABORATORY	0.414733	39,735	16,479	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.315809	2,490	786	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.175780	28,830	5,068	65
66	PHYSICAL THERAPY	0.359962	102,817	37,010	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332079	308,071	102,304	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.222754	3,487,098	776,765	72
73	DRUGS CHARGED TO PATIENTS	0.187079	331,401	61,998	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.877611			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		6,233,057	1,299,101	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		6,233,057		202

(A) Worksheet A line numbers



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ORTHOPAEDIC HOSPT.AT PARKVIEW Provider CCN: 15-0167	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 11:57 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	5,940,340			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	2,005,268			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	173,047			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS	5,357,171			3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	36.30			4
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS</b>				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS				7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2)(iv) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002				8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS				8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (see instructions)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON</b>				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	<b>DISPROPORTIONATE SHARE ADJUSTMENT</b>				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)				30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO OCTOBER 1	ON OR AFTER OCTOBER 1		
	<b>UNCOMPENSATED CARE ADJUSTMENT</b>				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				36
	<b>ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES</b>				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART 1 EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



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## CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

## CHECK

## APPLICABLE BOX:

## PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	8,118,655			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	8,118,655			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	648,121			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	8,766,776			59
60	PRIMARY PAYER PAYMENTS				60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	8,766,776			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	735,903			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES				63
64	ALLOWABLE BAD DEBTS (see instructions)	21,624			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	14,056			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	14,232			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	8,044,929			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	21,082			70.93
71	AMOUNT DUE PROVIDER (see instructions)	8,066,011			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	121,797			71.01
72	INTERIM PAYMENTS	7,941,442			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	2,772			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				75

## TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0167

WORKSHEET E  
PART B

CHECK APPLICABLE BOX:  HOSPITAL     IPF     IRF     SUB (OTHER)     SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	1,854,176			2
3	PPS PAYMENTS	1,799,557			3
4	OUTLIER PAYMENT (see instructions)	95,839			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	1,895,396			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	365,359			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	1,530,037			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,530,037			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	1,530,037			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	27,034			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	17,572			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	23,541			36
37	SUBTOTAL (see instructions)	1,547,609			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,547,609			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	23,369			40.01
41	INTERIM PAYMENTS	1,507,292			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	16,948			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-0167

WORKSHEET E-1  
PART I

CHECK  HOSPITAL  SUB (OTHER)  
 APPLICABLE  IPF  SNF  
 BOXES:  IRF  SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		7,941,442		1,507,292	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
	PROGRAM	.01				3.01
	TO	.02				3.02
	PROVIDER	.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	PROVIDER	.52				3.52
	TO	.53				3.53
	PROGRAM	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,941,442		1,507,292	4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
	PROGRAM	.01				5.01
	TO	.02				5.02
	PROVIDER	.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	PROVIDER	.52				5.52
	TO	.53				5.53
	PROGRAM	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	124,569		40,317	6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		8,066,011		1,547,609	7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



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## CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK                    [XX] HOSPITAL   [   ] CAH  
 APPLICABLE BOX:

## TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

## HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	2,017	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,669	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	1,106	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,950	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	270,365,788	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	347,422	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	915,032	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	18,301	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	896,731	10

## INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	873,926	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	22,805	32



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-0167

WORKSHEET E-3  
PART VII

CHECK  TITLE V  HOSPITAL  NF  PPS  
 APPLICABLE  TITLE XIX  SUB (OTHER)  ICF/MR  TEFRA  
 BOXES:  SNF  OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES		1,713,863	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)		1,713,863	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)		1,713,863	7
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	220,340		8
9	ANCILLARY SERVICE CHARGES	6,233,057	9,492,389	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	6,453,397	9,492,389	12
	<b>CUSTOMARY CHARGES</b>			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	6,453,397	9,492,389	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	6,453,397	7,778,526	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)		1,713,863	21
	<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22	OTHER THAN OUTLIER PAYMENTS	1,176,465		22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)	1,176,465		27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	1,176,465	1,713,863	29
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	1,176,465	1,713,863	31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	1,176,465	1,713,863	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	1,176,465	1,713,863	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	1,176,465	1,713,863	40
41	INTERIM PAYMENTS	1,176,465	1,713,863	41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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## BALANCE SHEET

## WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT ASSETS</b>						
1	CASH ON HAND AND IN BANKS	4,693,539				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	17,770,555				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY					7
8	PREPAID EXPENSES	1,518,319				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	23,982,413				11
<b>FIXED ASSETS</b>						
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	9,446,043				15
16	ACCUMULATED DEPRECIATION	-1,280,991				16
17	LEASEHOLD IMPROVEMENTS	1,505,293				17
18	ACCUMULATED AMORTIZATION	-487,497				18
19	FIXED EQUIPMENT	157,301				19
20	ACCUMULATED DEPRECIATION	-49,654				20
21	AUTOMOBILES AND TRUCKS	19,893				21
22	ACCUMULATED DEPRECIATION	-14,919				22
23	MAJOR MOVABLE EQUIPMENT	17,043,641				23
24	ACCUMULATED DEPRECIATION	-6,471,469				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	19,867,641				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS	199				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	57,965,933				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	57,966,132				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	101,816,186				36
<b>LIABILITIES AND FUND BALANCES</b>						
	(Omit Cents)	1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	3,857,477				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	7,580,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	18,154				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	11,455,631				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	23,709,150				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	17,658,945				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	41,368,095				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	52,823,726				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	48,992,460				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	48,992,460				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	101,816,186				60



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCES AT BEGINNING OF PERIOD		38,424,970		1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		56,567,490		2
3	TOTAL (sun of line 1 and line 2)		94,992,460		3
4	ADDITIONS (credit adjustments)				4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)				10
11	SUBTOTAL (line 3 plus line 10)		94,992,460		11
12	DEDUCTIONS (debit adjustments)				12
13	TRANSFERS	46,000,000			13
14					14
15					15
16					16
17					17
18	TOTAL DEDUCTIONS (sum of lines 12-17)		46,000,000		18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		48,992,460		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCES AT BEGINNING OF PERIOD				1
2	NET INCOME (loss) (from Worksheet G-3, line 29)				2
3	TOTAL (sun of line 1 and line 2)				3
4	ADDITIONS (credit adjustments)				4
5					5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)				10
11	SUBTOTAL (line 3 plus line 10)				11
12	DEDUCTIONS (debit adjustments)				12
13	TRANSFERS				13
14					14
15					15
16					16
17					17
18	TOTAL DEDUCTIONS (sum of lines 12-17)				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)				19



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## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
PARTS I & II

## PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	HOSPITAL	6,247,620		6,247,620	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	6,247,620		6,247,620	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	6,247,620		6,247,620	17
18	ANCILLARY SERVICES	151,555,196		151,555,196	18
19	OUTPATIENT SERVICES		69,622,061	69,622,061	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		50,290,457	50,290,457	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	157,802,816	119,912,518	277,715,334	28

## PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		61,646,340	29
30	BAD DEBT EXPENSE	3,169,116		30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)		3,169,116	36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		64,815,456	43



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## STATEMENT OF REVENUES AND EXPENSES

## WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	277,715,334	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	158,861,882	2
3	NET PATIENT REVENUES (line 1 minus line 2)	118,853,452	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	64,815,456	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	54,037,996	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	-8,723	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	1,745,553	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.02	OTHER (OTHER OPERATING INCOME)	802,321	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	2,539,151	25
26	TOTAL (line 5 plus line 25)	56,577,147	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)	9,622	27
27.01	OTHER EXPENSES (LOSS ON INVESTMENT)		27.01
27.02	OTHER EXPENSES (ROUNDING)		27.02
27.99	OTHER EXPENSES (MINOR TO BALANCE)	35	27.99
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	9,657	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	56,567,490	29



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0167

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] SUB (OTHER) [ ] COST METHOD  
 BOXES: [ ] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	629,915	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	18,206	2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	14.00	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	648,121	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 15-0167

WORKSHEET L

CHECK  TITLE V  HOSPITAL  PPS  
 APPLICABLE  TITLE XVIII, PART A  SUB (OTHER)  COST METHOD  
 BOXES:  TITLE XIX

**PART I - FULLY PROSPECTIVE METHOD**

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

**PART II - PAYMENT UNDER REASONABLE COST**

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS						30
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
	<b>SPECIAL PURPOSE COST CENTERS</b>						
115	AMBULATORY SURGICAL CENTER (D.P.)						115
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202