payments mad	is required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail de since the beginning of the cost reporting period being D HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	deemed overpayments (4)	2 USC 1395g).	OMB NO. 0938-0050
AND SETTLEM	ENT SUMMARY	Provider CCN: 150168	Period: From 01/01/2015 To 12/31/2015	
	ST REPORT STATUS			7 31/ E010 10.27 am
Provider use only	<ol> <li>[ X ] Electronically filed cost report</li> <li>[ ] Manually submitted cost report</li> <li>[ 0 ] If this is an amended report enter the number of the filed control of the filed</li></ol>	f times the provider re	Date: 5/31/20 esubmitted this c	
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for t (3) Settled with Audit (4) Reopened (5) Amended	10.N 11.C this Provider CCN 12.[		or Code: 4 clumn 1 is 4: Enter des reopened = 0-9.
PART II - CE				
PROVIDED OR	ATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN TH: VE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FI PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A P VE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	JRTHERMORE, IF SERVICES	IDENTIFIED IN TH	ITS REPORT WERE
	CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER	(S)		
	ANTICIPATO PER			

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN MUSCULOSKELETAL CENTER (150168) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information** 

ECR: Date: 5/31/2016 Time: 10:27 am Q5M7.h1GwHNmarR2IJ:ZewHHkdIoZ0 5GQnq0FFnwGw:47axBd9laovg6y3rE 0E.Y0vBChh0hpxHJ

PI: Date: 5/31/2016 Time: 10:27 am rYc.m2wTEiMjCcOYLPABHHi18vg7v0 vtew700003eTIqdqJMb1HqPFPjlJ6p XA210:Fyhs0.drz0

(Signed)

Officer or Administrator of Provider(s)

Senior Vice President, Revenue Management

5/31/2016

Title XVIII Title V Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 Hospital 3,563 45,391 -8.049 814,606 1.00 2.00 Subprovider - IPF 0 0 0 0 2.00 3.00 Subprovider - IRF 0 0 0 0 3.00 5.00 Swing bed - SNF 0 0 0 0 5.00 6.00 Swing bed - NF 0 6.00 200.00 Total 0 3,563 45,391 -8.049814,606 200.00 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150168 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 10: 23 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7952 W. JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46804 County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN 150168 23060 1 03/07/2008 Ν 0 3.00 MUSCULOSKELETAL CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 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) 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23 00 2 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 enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2. out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

	Financial Systems LUTHERAN M  AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider (	CCN: 150168	Peri od:	n Lie		m CMS-: eet S-2	
105P1 1	AL AND HUSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider		From 01/01 To 12/31		Part I Date/Ti		pared:
			·		Urban/Ru		Date of	Geogr	
26. 00	Enter your standard geographic classification (not wa	ige) sta	atus at the beg	inning of the	1.00	ر 1	2. (	00	26. 0
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ige) sta	atus at the end			1			27. 0
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cati on	in column 2.			0			35. C
	perredt in the dost reporting perred.				Begi nni		Endi		
36. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00	)	2. (	00	36. C
	of periods in excess of one and enter subsequent date	es.	•			0			
37.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	tne nu	umber of period	S MDH STATUS		Ü			37.0
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
	jenter subsequent dates.				Y/N		Υ/	'N	
39. 00	Does this facility qualify for the inpatient hospital	navmer	nt adjustment f	or low volume	1. 00 e N	)	2. (		39. (
39.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ent∈ µui remer	er in column 1 nts in accordan	"Y" for yes ce with 42	N			•	39. (
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	- N		N		40.0
		,				V 1 00	XVIII		
	Prospective Payment System (PPS)-Capital					1.00	0 2.00	3.00	
5. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)					N	N	N	45. (
6. 00	Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.			N	N	N	46.		
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment Teaching Hospitals						N N	N N	47. 48.
6. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56.
7. 00	If line 56 is yes, is this the first cost reporting pGME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th ", comp	r "N" for no in nis cost report olete Worksheet	column 1. If ing period?	column 1 Enter "Y"	N			57.
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.		as	N			58.
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				7	N N			59. 60.
	provider-operated criteria under §413.85? Enter "Y"	for yes	or "N" for no	. (see instru	uctions)				00.
		Y/N	I ME	Direct GME	IME	•	Di rec	t GME	
1 00	Did was basis to large to the same to the	1.00	2. 00	3. 00	4.00		5. (		1
1. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0. 00	61.
1. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. 00	0. (	00				61.
1. 02	<pre>instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of</pre>		0. 00	0. 0	00				61.
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	0.0	00				61.
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.0	00				61.
1. 05	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. 00	0.0	00				61.
1 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being		0. 00	0.0	00				61.

From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 10:23 am Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

Health Financial Systems LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/2015 o 12/31/2015		epared:
			V	XI X	25 4111
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			1. 00 0. 00 N	2.00 0.00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable column	ı.	0.00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 of this facility qualifies as a CAH, has it elected the all	,	nod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If	N		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	0ccupational 2.00	Speech 3.00	Respiratory 4.00	+
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109. 00
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (410	M Demolfor	1. 00 N	110. 00
the current cost reporting period? Enter "Y" for yes or "N"		on project (416	A Delilo) Tol	IN .	110.00
			1. 00	0 2.00 3.00	
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on is yes, enter the method used (A, B, or E only) in column 2 a either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide	. If column 2 i nt for long ter	is "E", enter i rm care (includ	n column les	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			N" for N		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence pol	licy? Enter 1 i	f the policy i	s 1		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 99, 529	2. 00 11, 022	3.00	118. 01
			1. 00	2.00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schemand amounts contained therein.			N N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y' ualifies for th	' for yes or ne Outpatient	N	N	119.00
121.00 Did this facility incur and report costs for high cost implements? Enter "Y" for yes or "N" for no.  Transplant Center Information	antable devices	s charged to	Y		121. 00
125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2		fication date			126. 00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 1	ter the certifi	cation date			127. 00
128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 1	ter the certifi	cation date			128. 00
129.00 If this is a Medicare certified lung transplant center, enti- column 1 and termination date, if applicable, in column 2.		cation date in			129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1		ti fi cati on			130. 00
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1.	r, enter the ce	erti fi cati on			131. 00
132.00 If this is a Medicare certified islet transplant center, enin column 1 and termination date, if applicable, in column 1	ter the certifi	cation date			132. 00
133.00 If this is a Medicare certified other transplant center, enin column 1 and termination date, if applicable, in column 2	ter the certifi 2.				133. 00
134.00  f this is an organ procurement organization (0P0), enter the land termination date, if applicable, in column 2.	he OPO number i	n column 1			134. 00

Health Financial Systems	LUTHERAN MUS	CULOSKELE	TAL CENTER				In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Provi der C	CN: 150168			/01/2015 /31/2015	Worksheet S-2 Part I Date/Time Pre 5/31/2016 10:	epared:
						1	. 00	2.00	-
All Providers  140.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N"							Y	449008	140. 00
are claimed, enter in column 2 the he							3. 00		
If this facility is part of a chain	 organi zati on,    enter		s 141 through	gh 143 th	e name	and		of the	
home office and enter the home office	e contractor name a	and contra	actor numbe	r					141 00
141.00 Name: COMMUNITY HEALTH SYSTEMS	Contractor's Nam	SERVI CI		AN CONTRA	ictor s	s ivuiii	Der: 5228	0	141. 00
142.00 Street: 4000 MERIDIAN BLVD 143.00 City: FRANKLIN	PO Box: State:	TN		Zip Co	ode:		3706	7	142. 00 143. 00
								1. 00	
144.00 Are provider based physicians' costs	included in Worksh	neet A?						Y	144. 00
						1	. 00	2.00	
145.00 of costs for renal services are claim inpatient services only? Enter "Y" for no, does the dialysis facility inclue period? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology	or yes or "N" for n de Medicare utiliza r no in column 2.	no in colu ntion for	umn 1. If co this cost r	olumn 1 is reporting	6		Y		145. 00
Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/	olumn 1. (See CMS P				lf		IN .		140.00
								1.00	-
147.00 Was there a change in the statistical								N	147. 00
148.00 Was there a change in the order of all 149.00 Was there a change to the simplified					for no.			N N	148. 00 149. 00
	-		Part A	Part E	3		tle V	Title XIX	
Does this facility contain a provide or charges? Enter "Y" for yes or "N"						n of			
155.00 Hospi tal			N	N			N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF			N N	N N			N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER			"						158. 00
159. 00 SNF			N	N			N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N N			N N	N N	160. 00 161. 00
		<u> </u>						1.00	
Multicampus	us hospital that ha	000.00	moro compilis	oe in di	fforon	+ CDC	Λε2	N	165.00
165.00 Is this hospital part of a Multicampu	us nosprtar tnať na ————	is one or	more campus		reren	r crs	MS!	IN .	165. 00
	Name		ounty	State			CBSA	FTE/Campus	-
166.00 If line 165 is yes, for each	0		. 00	2. 00	3. 00	U	4. 00	5.00	166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1. 00	
Health Information Technology (HIT) 167.00 s this provider a meaningful user u						ct		Υ	167. 00
168.00 If this provider is a CAH (line 105) reasonable cost incurred for the HIT	is "Y") and is a me	ani ngful				nter	the	l .	0168. 00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? El	a meaningful user, nter "Y" for yes or	does thi "N" for	no. (see ir	nstructi or	ns)		•		168. 01
169.00 If this provider is a meaningful user transition factor. (see instructions		and IS r	iota CAH (I	rne 105 I	S N'	ر, en	iter the	0.2	5169. 00
							i nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR beginnering respectively (mm/dd/yayy)	inning date and end	ding date	for the rep	orti ng			1. 00 01/2014	2. 00 12/29/2014	170. 00
period respectively (mm/dd/yyyy)					1			l	

Health Financial Systems	LUTHERAN MUSCULOSKELI	ETAL CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II	DENTIFICATION DATA	Provider CCN: 150168	From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/31/2016 10:	
				1.00	
171.00 If line 167 is "Y", does this provide	N	171. 00			
Medicare cost plans reported on Wkst. (see instructions)					

		THERAN MUSCULOSKELETAL CENTER			eu of Form CMS-	
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI UNNAI RE Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		epared:
		,	<u>'</u>	Y/N	Date	
	General Instruction: Enter Y for all YES resp	oonsos Entor N for all NO ro	spansos Entor	1.00	2.00	-
	mm/dd/yyyy format.	oonses. Enter N for all No re	sponses. Enter	air dates in	tne	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the heginning of	the cost	N	I	1.00
1.00	reporting period? If yes, enter the date of			IN IN		1.00
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in	the Medicare Program? If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination		l IV			2.00
2 00	voluntary or "I" for involuntary.		,,			2.00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or in relationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board	Y			3.00
	Total delicing por (esse more delicine)		Y/N	Type	Date	
	Fi manai al Data ard Daviette		1. 00	2. 00	3. 00	
4.00	Financial Data and Reports  Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	N			4.00
5. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5. 00
	those on the filed financial statements? If					
				1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is th	ne provider is	N		6.00
7. 00	the Legal operator of the program? Are costs claimed for Allied Health Programs?	2 If "V" see instructions		N		7. 00
8. 00	Were nursing school and/or allied health programs		I during the	N		8. 00
0.00	cost reporting period? If yes, see instruction			N		0.00
9. 00	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s		ar education	N		9. 00
10.00	Was an approved Intern and Resident GME progr	ram initiated or renewed in t	he current	N		10.00
11. 00	cost reporting period? If yes, see instruction  Are GME cost directly assigned to cost center		vrovod	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see		n oved	IN		11.00
					Y/N	
	Bad Debts				1.00	+
	Is the provider seeking reimbursement for bac	d debts? If yes, see instruct	i ons.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad del	ot collection policy change d	luring this cos	t reporting	N	13.00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	and/or co-payments waived? If	ves see inst	ructi ons	N	14. 00
00	Bed Complement	and or so paymontes war rou	- Jack 200 11101	. 4011 01101		]
15. 00	Did total beds available change from the price	or cost reporting period? If			N	15.00
		Description	Y/N	t A Date	Part B Y/N	+
		0	1.00	2. 00	3. 00	
44.00	PS&R Data		1	05 (40 (004 (		1, 00
16. 00	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		Y	05/13/2016	Y	16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		N		N	17. 00
18. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N		N	18. 00
19. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of		N		N	19. 00
20. 00	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe		N		N	20.00

Health Financial Systems	LUTHERAN MUSCULOSKELET	TAL CENT	ER		In Lieu	of Form	m CMS-2552-10
				T			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Worksheet S-2 Provider CCN: 150168 Peri od: From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the N 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 copy Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position BRI TTNI KING 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. COMMUNITY HEALTH SYSTEMS 42.00 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 615-465-2769 BRI TTNI \_KI NG@CHS. NET 43.00 report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150168 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/31/2016 10: 23 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 05/13/2016 16.00 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) 17.00 Was the cost report prepared using the PS&R 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position SENIOR MANAGER, REVENUE 41.00 held by the cost report preparer in columns 1, 2, and 3, MANAGEMENT respecti vel y. Enter the employer/company name of the cost report 42.00 42.00

43.00

preparer.

Enter the telephone number and email address of the cost

report preparer in columns 1 and 2, respectively.

43.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | | To 12/31/2015 | Date/Time Prepared: 
 Heal th Financial
 Systems
 LUTHERAN M

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provi der CCN: 150168

						То	12/31/2015	Date/Time Pr 5/31/2016 10		
								I/P Days / 0/		o diii
								Visits / Trip		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V		
		1.00		2.00	3. 00		4. 00	5. 00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		39	14, 23	35	0.00		0	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)									
2. 00	HMO and other (see instructions)								- 1	2. 00
3.00	HMO IPF Subprovider								1	3. 00
4. 00	HMO IRF Subprovider								- 1	4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF								o	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF								0	6. 00
7.00	Total Adults and Peds. (exclude observation			39	14, 23	35	0.00		0	7.00
	beds) (see instructions)								-	
8.00	INTENSIVE CARE UNIT								-	8. 00
9.00	CORONARY CARE UNIT								-	9. 00
10.00	BURN INTENSIVE CARE UNIT								-	10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)								- 1	11. 00 12. 00
13. 00	NURSERY								- 1	13. 00
14. 00	Total (see instructions)			39	14, 23	35	0.00		ol	14. 00
15. 00	CAH visits			0,	1, 20		0.00		ŏ	15. 00
16. 00	SUBPROVIDER - IPF								Ì	16.00
17.00	SUBPROVI DER - I RF								- [	17.00
18.00	SUBPROVI DER									18.00
19. 00	SKILLED NURSING FACILITY									19. 00
20. 00	NURSING FACILITY									20. 00
21. 00	OTHER LONG TERM CARE								-	21. 00
22. 00	HOME HEALTH AGENCY								-	22. 00 23. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE								-	24. 00
24. 00	HOSPICE (non-distinct part)	30. 00							- 1	24. 10
25. 00	CMHC - CMHC	30.00							1	25. 00
26. 00	RURAL HEALTH CLINIC								ı	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER								- 1	26. 25
27. 00	Total (sum of lines 14-26)			39	1				- 1	27.00
28. 00	Observation Bed Days								0	28. 00
29. 00	Ambul ance Tri ps								-	29. 00
30. 00	Employee discount days (see instruction)								-	30. 00
31.00	Employee discount days - IRF			-						31.00
32.00	Labor & delivery days (see instructions)			0		0				32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)									32. 01
33. 00	LTCH non-covered days									33. 00
	1				T. Control of the Con	- 1			- 1	

Provi der CCN: 150168

Title XVIII							5/31/2016 10:	23 am
No.   Hospital Adults & Peds. (columns 5. 6. 7 and 8 and 8 acclude Swing Bed, Observation Bed and Hospice days) (see instructions)   1,516   0   0   0   0   0   0   0   0   0			I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   1,00   2,00		Component	Title XVIII	Title XIX				
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8								
8 exclude Swing Bed, Observation Bed and Hospice days) (soe instructions for col. 2 for the portion of LDP room available beds)   2		I					10.00	
Hospi ce days) (see instructions for col. 2 for the portion of LDP room available beds)   2.00   HM0 and other (see instructions)   1,516   0   0   0   0   0   0   0   0   0	1. 00		1, 798	384	5, 939			1. 00
For the portion of LDP room available beds)   1,516   0   2.00   0   0   0   0   0   0   0   0   0								
2.00 HM0 and other (see instructions)								
3.00	2 00		1 516	0				2 00
4.00			1, 310	0				
5.00		•	o o	0				
6.00   Hospital Adults & Peds. Swing Bed NF   0   0   0   6.00		· ·	o o	0	0			
7.00				0	Ö			
beds) (see instructions)   8.00     NTENSIVE CARE UNIT   9.00     10.00   BURN INTENSIVE CARE UNIT   10.00     11.00   SURRI INTENSIVE CARE UNIT   11.00     12.00   OTHER SPECIAL CARE (SPECIFY)   12.00     13.00   NURSERY   12.00     14.00   Total (see instructions)   1,798   384   5,939   0.00     15.00   CAH visits   0   0   0     16.00   SUBPROVIDER - IPF   15.00     17.00   SUBPROVIDER - IRF   17.00     18.00   SUBPROVIDER - IRF   18.00     19.00   SKILLED NURSING FACILITY   19.00     10.00   ONURSING FACILITY   20.00     10.00   ONUR HEALTH AGENCY   22.00     23.00   ANBULATORY SURGICAL CENTER (D.P.)   22.00     10.00   ONUR HEALTH AGENCY   22.00     24.10   HOSPICE (non-distinct part)   0   0   0     25.00   CMC - CMC   25.00     26.00   RURAL HEALTH CLINIC   25.00     26.00   RURAL HEALTH CLINIC   25.00     26.00   ONURAL Health CLINIC   25.00     27.00   Onural Health CLINIC   25.00     28.00   Onural Health CLINIC   25.00     29.00   Onural Health CLINIC   25.00     20.00   Onural Health CLINIC			1, 798	384	5, 939			
9.00   COROMARY CARE UNIT   9.00   10.00   BURN INTENSIVE CARE UNIT   11.00   10.00			·					
10.00   BURN INTENSIVE CARE UNIT   10.00   11.00   1	8.00	INTENSIVE CARE UNIT						8. 00
11. 00   SURGICAL INTENSIVE CARE UNIT   12. 00   OTHER SPECIAL CARE (SPECIFY)   13. 00   OTHER SPECIAL CARE (SPECIFY)   13. 00   OTHER SPECIAL CARE (SPECIFY)   14. 00   OTHER SPECIAL CARE (SPECIFY)   15. 00   OTHER LONG SUBPROVIDER - IPF   OTHER LONG SUBPROVIDER - IPF   OTHER LONG SUBPROVIDER - IRF   OTHER LONG SUBPROVIDER   OTHER LONG SUBPROVIDER   OTHER LONG STRING FACILITY   OTHER LONG STRING FACILITY   OTHER LONG STRING FACILITY   OTHER LONG STRING CARE   OTHER LONG STRING CARE   OTHER LONG SUBPROVIDER   OTHER LONG STRING CARE   OTHER LONG SUBPROVIDER   OTHER LONG STRING CARE   OTHER LONG STRING STR	9.00	CORONARY CARE UNIT						9. 00
12. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 15. 00 16. 00 18. 00 18. 00 19	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00   NURSERY   1.798   384   5,939   0.00   224.66   14.00   15.00   CAH visits   0   0   0   0   0   0   15.00   CAH visits   0   0   0   0   0   0   0   15.00   16.00   SUBPROVI DER - IPF   0   0   0   0   0   0   15.00   16.00   15.00   16.00   15.00   16.00   15.00   16.00   17.00   SUBPROVI DER - IRF   0   0   0   0   0   0   0   0   0	11. 00							11. 00
14. 00 Total (see instructions)								
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 20. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		y control of the cont						
16.00   SUBPROVIDER - IPF   16.00   17.00   SUBPROVIDER - IRF   18.00   17.00   SUBPROVIDER - IRF   18.00   17.00   17.00   17.00   18.00   18.00   19.00   SKILLED NURSING FACILITY   19.00		1	1, 798			0.00	224. 66	
17. 00   SUBPROVIDER - IRF   17. 00   18. 00   19. 00   SUBPROVIDER   18. 00   19. 00   SUBLED NURSING FACILITY   19. 00   20. 00   NURSING FACILITY   20. 00   NURSING FACILITY   21. 00   22. 00   24. 00   HOME HEALTH AGENCY   23. 00   AMBULATORY SURGICAL CENTER (D. P. )   23. 00   24. 10   HOSPICE   26. 00   CMHC - CMHC   25. 00   CMHC - CMHC   26. 00   RURAL HEALTH CENTER   26. 25   27. 00   Cmservation Bed Days   0   139   29. 00   24. 66   27. 00   27. 00   27. 00   28. 00   29. 00   29. 00   30. 00   29. 00   30. 00   29. 00   31. 00   Employee discount days (see instruction)   0   0   0   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   32. 01   33. 00   32. 01   34. 00   33.		1	0	0	0			
18.00   SUBPROVI DER   18.00   19.00   SKI LLED NURSI NG FACI LITY   19.00   20.00   NURSI NG FACI LITY   20.00   OTHER LONG TERM CARE   21.00   22.00   HOME HEALTH AGENCY   22.00   AMBULATORY SURGI CAL CENTER (D. P. )   23.00   24.00   HOSPI CE   (non-distinct part)   0   0   0   24.10   25.00   CMHC - CMHC   25.00   24.10   25.00   CMHC - CMHC   26.00   26.25   FEDERALLY QUALIFIED HEALTH CENTER   26.25   27.00   Total (sum of lines 14-26)   28.00   29.00   Ambulance Trips   0   0   0   224.66   27.00   29.00		1						
19. 00 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 44. 00 HOSPICE 44. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 0 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 0 19. 00 20. 00 20. 00 20. 00 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1						
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   21.00   22.00   22.00   40ME HEALTH AGENCY   23.00   40.00   40.00   40.00   40.00   22.00								
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  41.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC  26.00 RURAL HEALTH CLINIC  26.00 Observation Bed Days  29.00 Ambulance Trips  30.00 Employee discount days (see instruction)  31.00 Employee discount days (see instructions)  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  21.00		1						
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		1						
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 0 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 30.01 Total ancillary labor & delivery room outpatient days (see instructions)		1						
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		1						
24. 10 HOSPICE (non-distinct part) 0 0 0 0 0 24. 10 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0 0 139 0 224. 66 27. 00 28. 00 Observation Bed Days 0 139 28. 00 29. 00 Ambulance Trips 0 29. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 0 31. 00 Employee discount days (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 02 Control outpatient days (see instructions) 30. 00 Outpatient days (see instructions) 30. 00 Outpatient days (see instructions) 30. 00 Outpatient days (see instructions)			0	0				
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 02 RURAL HEALTH CLINIC 26. 00 26. 02 27. 00 28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 01			J	0	Ĭ			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & see instructions)								
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
28.00   Observation Bed Days   28.00   29.00   Ambulance Trips   0   29.00   30.00   Employee discount days (see instruction)   0   31.00   Employee discount days - IRF   0   31.00   232.00   Labor & delivery days (see instructions)   0   0   0   0   32.00   32.01   Total ancillary labor & delivery room outpatient days (see instructions)   0   0   32.01   0   0   0   0   0   0   0   0   0						0.00	224. 66	27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 30.00 31.00 31.00 32.00 32.01	28. 00			0	139			28. 00
31.00 Employee discount days - IRF  32.00 Labor & delivery days (see instructions)  Total ancillary labor & delivery room outpatient days (see instructions)  31.00  0  31.00  32.00	29.00	Ambul ance Trips	0					29. 00
32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 32.01	30.00	Employee discount days (see instruction)			0			30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	31.00	Employee discount days - IRF			0			31.00
outpatient days (see instructions)	32.00	Labor & delivery days (see instructions)	0	0	0			32.00
	32. 01				0			32. 01
33.00  LTCH non-covered days   0    33.00								
	33. 00	LICH non-covered days	0		l		l	33.00

TAL CENTER

Provider CCN: 150168
Period:
From 01/01/2015
To 12/31/2015
Part I
To 12/31/2015
Part J
Date/Time Prepared:

	To 12/31/2015						oared: 23 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	740	142	2, 599	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			637	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	C	740	142	2, 599	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00 22. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)	0. 00					27.00
28.00	Observation Bed Days						28.00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						33. 00
33.00	LTCH non-covered days	I			I	ı	33.00

Provi der CCN: 150168

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016

					To	12/31/2015	Date/Time Pre 5/31/2016 10:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries (from	Sal ari es (col . 2 ± col .	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col . 4	COI . 3)	
	2007 11 11007 2071	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	12, 354, 881	0	12, 354, 881	467, 289. 00	26. 44	1.00
0.00	instructions)					0.00		
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	B  Physician-Part A -		0		0	0.00	0.00	4. 00
1. 00	Admi ni strati ve				Ĭ	0.00	0.00	1.00
4. 01	Physicians - Part A - Teaching		0	-	0	0.00		
5. 00 6. 00	Physician-Part B Non-physician-Part B		0	1	0	0. 00 0. 00	l .	
7. 00	Interns & residents (in an	21. 00	0	O	0	0.00		
7. 01	approved program) Contracted interns and		0			0. 00	0.00	7. 01
7.01	resi dents (in an approved		O	,		0.00	0.00	7.01
8. 00	programs) Home office personnel		0			0.00	0. 00	8. 00
9. 00	SNF	44. 00	0	0	0	0.00		
10.00	Excluded area salaries (see		919, 238	101, 253	1, 020, 491	47, 384. 00	21. 54	10.00
	instructions) OTHER WAGES & RELATED COSTS							1
11.00	Contract labor: Direct Patient		103, 647	0	103, 647	1, 760. 00	58. 89	11. 00
12.00	Care		E E20	0	E E30	13. 32	415 04	12.00
12. 00	Contract labor: Top level management and other		5, 539		5, 539	13. 32	415.84	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		21, 230	0	21, 230	117. 00	181 45	13. 00
10.00	A - Administrative							10.00
14. 00	Home office salaries & wage-related costs		940, 300	0	940, 300	15, 035. 00	62. 54	14.00
15. 00	Home office: Physician Part A		0	o	О	0.00	0. 00	15. 00
1/ 00	- Administrative		0	0		0.00	0.00	14 00
16. 00	Home office and Contract Physicians Part A - Teaching		O	,		0. 00	0.00	16. 00
47.00	WAGE-RELATED COSTS		0.057.040		0.051.040		I	1
17. 00	Wage-related costs (core) (see instructions)		2, 356, 012	0	2, 356, 012			17. 00
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		249, 894		249, 894			19. 00
20. 00	Non-physician anesthetist Part		247, 074	Ö	247,074			20.00
21 00	A		0					21 00
21. 00	Non-physician anesthetist Part B		U	,	U			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	1	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)   Interns & residents (in an		0	1	0			24. 00 25. 00
23.00	approved program)							25.00
27.00	OVERHEAD COSTS - DIRECT SALARIE					0.00	0.00	2/ 00
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	2, 298, 478		2, 034, 849	0. 00 75, 196. 00		1
28. 00	Administrative & General under		0	0	0	0.00		•
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0			0. 00	0. 00	29. 00
30.00	Operation of Plant	7. 00	47, 492	Ö	47, 492	1, 849. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		1
32. 00 33. 00	Housekeeping under contract	9. 00	0	0	0	0. 00 0. 00	l .	•
	(see instructions)		_					
34. 00 35. 00	Di etary Di etary under contract (see	10. 00	0	1	0	0. 00 0. 00		1
აა. UU	instructions)		U	ή		0.00	0.00	33.00
36.00	Cafeteri a	11. 00	0	0	0	0.00		
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 120, 792	0 162, 376	0 283, 168	0. 00 5, 205. 00		
39. 00	Central Services and Supply	14. 00	326, 235	0	326, 235	21, 086. 00	15. 47	39. 00
40. 00	Pharmacy	15. 00	0	0	0	0.00	0.00	40. 00

HOSPITAL WAGE INDEX INFORMATION  Provider CCN: 150168   Period: From 01/01/2015 To 12/31/2015   Date/Time Prepared: 5/31/2016 10:23 am    Worksheet A Line Number   Reported   R	nancial Systems	Heal th	Heal th	th Financial Systems	LU	THERAN MUSCUL	OSKELETA	L CENTER	?		In Lie	u of Form CMS-2	<u> 2552-10</u>	l
Worksheet A Line Number Reported Reported On of Salaries (from Worksheet A-6) 3)  To 12/31/2015 Date/Time Prepared: 5/31/2016 10: 23 am  Paid Hours Related to Wage (col. 4 ÷ col. 5) col. 4	WAGE INDEX INFORMATION	HOSPI TA	HOSPI 7	PITAL WAGE INDEX INFORMATION			P	rovi der	CCN: 150168	Perio	od:	Worksheet S-3		
Worksheet A Line Number Reported Report														
Worksheet A Line Number Reported Reported Office (col. 2 ± col. Salaries in col. 4 **  Worksheet A Amount Reclassificati Adjusted Salaries Salaries (col. 2 ± col. Salaries in col. 5)  Worksheet A-6) 3) col. 4										To	12/31/2015			
Line Number Reported on of Salaries Salaries Related to Wage (col. 4 ÷ (col. 2 ± col. Salaries in col. 5)  Worksheet A-6) 3) col. 4										_		5/31/2016 10:	23 am	
(from (col.2 ± col. Salaries in col.5) Worksheet A-6) 3) col.4					Worksheet A	Amount	Recl as:	si fi cati	Adj usted	Pa	aid Hours	Average Hourly		
Worksheet A-6) 3) col. 4					Line Number	Reported	on of S	Sal ari es	Sal ari es	Re	elated to	Wage (col. 4 ÷		
							(f	rom	(col.2 ± col	. Sa	alaries in	col. 5)		
							Worksh	eet A-6)	3)		col. 4			
1.00 2.00 3.00 4.00 5.00 6.00					1.00	2.00	3.	00	4. 00		5. 00	6. 00		
41.00 Medical Records & Medical 16.00 0 0 0 0.00 0.00 41.00	dical Records & Medical	41.00	41.00	00 Medical Records & Medical	16. 00		0	0		0	0. 00	0. 00	41.00	
Records Library	cords Library			Records Library										
42. 00   Social Service   17. 00   0   0   0   0. 00   42. 00	ci al Servi ce	42.00	42.00	00 Social Service	17. 00	1	0	0		0	0.00	0. 00	42.00	
43.00 Other General Service 18.00 0 0 0 0.00 0.00 43.00	her General Service	43. 00	43. 00	00 Other General Service	18.00		o	0		0	0. 00	0. 00	43. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2015 | Part III | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 | Date Provi der CCN: 150168

							5/31/2016 10:	23 am
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		12, 354, 881	0	12, 354, 881	467, 289. 00	26. 44	1. 00
	instructions)							
2.00	Excluded area salaries (see		919, 238	101, 253	1, 020, 491	47, 384. 00	21. 54	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		11, 435, 643	-101, 253	11, 334, 390	419, 905. 00	26. 99	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		1, 070, 716	0	1, 070, 716	16, 925. 32	63. 26	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		2, 356, 012	0	2, 356, 012	0.00	20. 79	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		14, 862, 371	-101, 253	14, 761, 118	436, 830. 32	33. 79	6. 00
7.00	Total overhead cost (see		2, 792, 997	-101, 253	2, 691, 744	103, 336. 00	26. 05	7. 00
	instructions)							

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15	
		From 01/01/2015   Part IV

	To 12/31/2015	Date/Time Prep 5/31/2016 10:2	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	221, 082	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 289, 126	8. 00
9.00	Prescription Drug Plan	o	9. 00
10.00	Dental, Hearing and Vision Plan	13, 722	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	9, 953	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	247	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	5, 655	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	ol	14.00
15.00	'Workers' Compensation Insurance	83, 077	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	ol	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	700, 980	17. 00
18.00	Medicare Taxes - Employers Portion Only	163, 939	18.00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	88, 367	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2, 576, 148	24. 00
	Part B - Other than Core Related Cost		
25. 00	ALLOCATED BENEFITS FROM LHN	29, 757	25. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150168	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part V Date/Time Prepared: 5/31/2016 10:23 am

		''	3 12/31/2015	5/31/2016 10:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovi der - I PF				3.00
4.00	Subprovi der - I RF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11. 00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16.00
17. 00	Renal Dialysis				17.00
18. 00	Other		0	0	18. 00

11.00 Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  79, 286  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Uncompensated and indigent care cost computation  1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Medicaid Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Not revenue from Sther osupplemental payments from Medicaid? Not revenue from stand-aline Sthern Sthern Medicaid? Not revenue from stand-aline Sthern Medicaid payments from Medicaid? Not revenue from stand-aline Sthern Medicaid program (line 7 minus sum of lines 2 and 5; if 789, 569  State Children's Health Insurance Program (Sthern) (see instructions for each line) Not revenue from stand-aline Sthern Sthern Stand-aline Sthern Cost (line 1 times line 10) Cost Stand-aline Sthern Cost (line 1 times line 10) Cost Stand-aline Sthern Cost (line 1 times line 10) Cost Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) Not revenue from state or local indigent care program (Not included in lines 6 or 10) Not State or local indigent care program cost (line 1 times line 14) Not State or local indigent care program cost (line 1 times line 14) Not State or local indigent care program cost (line 1 times line 14) Not State or local indigent care program cost (line 1 times line 14) Not State or local indigent care program (line	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Uncompensated and indigent care cost computation  1.00  Cost to charge ratio (Worksheet C, Part   line 202 column 3 divided by line 202 column 8)  Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?  5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid  6.00 Medicaid cost (line 1 times line 6)  8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789, 569 <a href="text-area">text-area to the intervenue from stand-alone SCHIP</a> 9.00 Net revenue from stand-alone SCHIP (see instructions for each line)  9.00 Net revenue from stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (Not included in lines 2, 5 or 9)  78,520  70,627	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
Uncompensated and indigent care cost computation  1.00  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  Medicaid (see instructions for each line)  2.00  Net revenue from Medicaid  1,920,105  3.00  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?  If line 4 is "no", then enter DSH or supplemental payments from Medicaid?  1.00  Medicaid charges  24,156,417  2,709,674  8.00  Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789,569  xate Children's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue from stand-alone SCHIP  10.00  Stand-alone SCHIP charges  0  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  78,520  706,827  707  708  709  700  700  700  700  70	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Uncompensated and indigent care cost computation  Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)  National (see instructions for each line)  Net revenue from Medicaid  1,920,105  3.00  Did you receive DSH or supplemental payments from Medicaid?  1,920,105  Net revenue from Medicaid all DSH or supplemental payments from Medicaid?  1,920,105  Nedicaid charges aline 2 include all DSH or supplemental payments from Medicaid?  1,920,105  Nedicaid charges aline 2 include all DSH or supplemental payments from Medicaid?  1,920,105  Nedicaid charges aline 2 include all DSH or supplemental payments from Medicaid?  1,920,105  Nedicaid charges aline 2 include all DSH or supplemental payments from Medicaid?  1,920,105  Nedicaid charges aline 2 include all DSH or supplemental payments from Medicaid?  2,709,674  2,709,674  Nedicaid cost (line 1 times line 6)  2,709,674  2,709,674  Nedicaid cost (line 1 times line 6)  State Children's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue from stand-alone SCHIP  Stand-alone SCHIP cost (line 1 times line 10)  10.00  Stand-alone SCHIP cost (line 1 times line 10)  11.00  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  Not revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  78,520  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 100, 827  10)  State or local indigent care program cost (line 1 times line 14)  79,286  16.00  Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Cost to charge ratio (Worksheet C, Part   line 202 column 3 divided by line 202 column 8)  Medicaid (see instructions for each line)  Net revenue from Medicaid  1,920,105  Noter revenue from Medicaid program from Medicaid  24,156,417  Noter revenue from stand-alone Schip from Medicaid program (line 7 minus sum of lines 2 and 5; if 789,569  2	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Medicaid (see instructions for each line)  2.00 Net revenue from Medicaid 1,920,105  3.00 Did you receive DSH or supplemental payments from Medicaid?  4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?  5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid  6.00 Medicaid charges  7.00 Medicaid cost (line 1 times line 6)  8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789, 569   7.00 x zero then enter zero)  8.00 State Children's Health Insurance Program (SCHIP) (see instructions for each line)  9.00 Net revenue from stand-alone SCHIP  9.00 Stand-alone SCHIP charges  11.00 Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  79, 286  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2.00 Net revenue from Medicaid 3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 6.00 Medicaid charges 7.00 Medicaid cost (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789,569 < zero then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9.00 Net revenue from stand-alone SCHIP 10.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then neter zero)	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 6.00 Medicaid charges 7.00 Medicaid cost (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789,569 < zero then enter zero) 8.00 State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9.00 Net revenue from stand-alone SCHIP 9.00 Stand-alone SCHIP cost (line 1 times line 10) 11.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 0 enter zero) 0 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then 0 enter zero) 13.00 Net revenue from state or local indigent care program (see instructions for each line) 13.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4.00 If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 5.00 If line 4 is "no", then enter DSH or supplemental payments from Medicaid 0 6.00 Medicaid charges 24,156,417 7.00 Medicaid cost (line 1 times line 6) 2,709,674 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789,569 < zero then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9.00 Net revenue from stand-alone SCHIP 9.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 life < zero then enter zero)	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Solid Charges   State Children's Health Insurance Program (SCHIP) (see instructions for each line)   Stand-alone SCHIP charges   Output	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
Medicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789, 569   Take thildren's Health Insurance Program (SCHIP) (see instructions for each line)  Net revenue from stand-alone SCHIP  Stand-alone SCHIP charges  Stand-alone SCHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  Net revenue from state or local indigent care program (Not included in lines 6 or 706, 827 lo)  Stand-alone SCHIP cost (line 1 times line 10)  Stand-alone SCHIP cost (line 1 times line 10)  Stand-alone SCHIP cost (line 1 times line 10)  Stand-alone SCHIP cost (line 1 times line 11 minus line 9; if < zero then 0 enter zero)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  78, 520  Take thild cost (line 1 times line 14)  Take thild care program (line 15 minus line 15 minus line 16)	6. 00 7. 00 8. 00 9. 00 10. 00
Medicaid cost (line 1 times line 6)  8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 789, 569 < zero then enter zero)  State Children's Health Insurance Program (SCHIP) (see instructions for each line)  9.00 Net revenue from stand-alone SCHIP  10.00 Stand-alone SCHIP charges  11.00 Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la); if < zero then enter zero)	7. 00 8. 00 9. 00 10. 00
<pre></pre>	9. 00 10. 00
<pre></pre>	10.00
9.00 Net revenue from stand-alone SCHIP 10.00 Stand-alone SCHIP charges 11.00 Stand-alone SCHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la); if < zero then enter zero)	10.00
10.00 Stand-alone SCHIP charges  Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la; if < zero then enter zero)	10.00
11.00 Stand-alone SCHIP cost (line 1 times line 10)  12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la; if < zero then enter zero)	
enter zero)  Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la; if < zero then enter zero)	11.00
Other state or local government indigent care program (see instructions for each line)  13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706, 827 lo)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 la; if < zero then enter zero)	12. 00
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  78,520  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 706,827 10)  15.00 State or local indigent care program cost (line 1 times line 14)  79,286  100 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	13. 00
15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 766 13; if < zero then enter zero)	14.00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	
13; if < zero then enter zero)	15.00
	16. 00
Uncomponented care /coo instructions for each line)	
Uncompensated care (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charity care  0	17. 00
	18. 00
	19. 00
8, 12 and 16)	
Uninsured Insured Total (col. 1	
patients patients + col. 2)	
20. 00 Total initial obligation of patients approved for charity care (at full 130, 100 188, 175 318, 275	20. 00
charges excluding non-reimbursable cost centers) for the entire facility	20.00
	21. 00
times line 20)	
22.00 Partial payment by patients approved for charity care 100 160 260	22.00
23.00 Cost of charity care (line 21 minus line 22) 14,494 20,948 35,442	23.00
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit N	
imposed on patients covered by Medicaid or other indigent care program?	24.00
	24. 00
	24. 00 25. 00 26. 00
	25. 00
	25. 00 26. 00
	25. 00 26. 00 27. 00 28. 00 29. 00
	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10

Heal th	Financial Systems L	LUTHERAN MUSCULOSKE	ELETAL CENTER	₹	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2015 Fo 12/31/2015	Date/Time Pre 5/31/2016 10:	
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		42, 859	42, 85	3, 878, 279	3, 921, 138	1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 119, 782			1, 573, 619	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	86, 261	86, 26		1, 738, 609	4. 00
5. 01	00570 ADMITTING	0	00, 201		1, 592, 157	1, 592, 157	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL-OTHER	2, 298, 478	31, 890, 541	34, 189, 01		27, 149, 998	5. 02
7.00	00700 OPERATION OF PLANT	47, 492	921, 666			966, 966	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	83, 453			83, 453	8. 00
9. 00	00900 HOUSEKEEPI NG	o	360, 578			360, 578	9. 00
10.00	01000 DI ETARY	o	326, 619			326, 619	10.00
13. 00	01300 NURSING ADMINISTRATION	120, 792	396, 846			679, 838	13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	326, 235	15, 574, 593			2, 007, 113	14. 00
15. 00	01500 PHARMACY	0	1, 903, 051	1, 903, 05		550, 382	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	421, 204			417, 110	16. 00
17. 00	01700 SOCIAL SERVICE	o	35, 524	35, 52		35, 524	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-1		
30.00	03000 ADULTS & PEDI ATRI CS	1, 963, 775	443, 015	2, 406, 79	0 0	2, 406, 790	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 491, 326	4, 469, 872	7, 961, 19	756, 759	8, 717, 957	50.00
51.00	05100 RECOVERY ROOM	1, 191, 716	382, 456	1, 574, 17:	2 -1, 574, 172	0	51.00
53.00	05300 ANESTHESI OLOGY	0	-201, 141	-201, 14	1 -44, 234	-245, 375	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	39, 163	298, 201	337, 36	4 32, 760	370, 124	54.00
54. 01	05401 ULTRASOUND	0	4, 183	4, 18:	-4, 183	0	54. 01
57.00	05700  CT SCAN	0	4, 160	4, 160	-4, 160	0	57. 00
58. 00	05800  MRI	78, 601	23, 299	101, 90	-101, 900	0	58. 00
60.00	06000 LABORATORY	4, 924	428, 736	433, 660	-114, 130	319, 530	60.00
65.00	06500 RESPI RATORY THERAPY	0	13, 447	13, 44	7 0	13, 447	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 749, 094	693, 329			2, 158, 535	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	123, 881	9, 144	133, 02	-133, 025	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	92	7	91		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	74	19, 225		1	19, 299	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	446, 280	446, 280	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		13, 489, 547	13, 489, 547	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 312, 025	1, 312, 025	73. 00
	OUTPATIENT SERVICE COST CENTERS			ı	_1 _1		
91. 00	09100 EMERGENCY	0	0	1	0	0	91. 00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
05 00	OTHER REIMBURSABLE COST CENTERS			1		0	05 00
95. 00	09500 AMBULANCE SERVI CES SPECIAL PURPOSE COST CENTERS	0	0	1	0	0	95. 00
118. 00		11, 435, 643	59, 750, 910	71, 186, 55	-775, 290	70, 411, 263	110 00
110.00	NONREI MBURSABLE COST CENTERS	11, 430, 043	39, 730, 910	71, 160, 33.	-113, 290	70, 411, 203	110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 826	41, 380	43, 20	940	44, 146	102 00
	19300 NONPALD WORKERS	1, 820	41, 300		0 940	44, 140	193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 00
	07951 SPORTS MARKETING	917, 412	157, 722	1, 075, 13	-38, 140	1, 036, 994	
	07952 MARKETI NG	717, 412	.57, 722		812, 490		
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 012, 170		194. 03
200.00	1	12, 354, 881	59, 950, 012	72, 304, 89	٥		
	1 1 2 1 2 1 2 1 2 1 2 1 7 7 7 7 7 7 7 7	.=, 50 1, 00 1	2.,.00,012	, 00., 07.	۱	, 55 ., 576	

Health FinancialSystemsLUTHERAN MUSCRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 150168 

				То	12/31/2015	Date/Time Prepared: 5/31/2016 10:23 am
	Cost Center Description	Adjustments	Net Expenses			3/31/2010 10. 23 8111
	oust defiter beschiptron		For Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 701, 369	1, 219, 769			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	173, 563	1, 747, 182			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-8, 671	1, 729, 938			4. 00
5. 01	00570 ADMITTING	-51, 126				5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL-OTHER	-21, 050, 154				5. 02
7.00	00700 OPERATION OF PLANT	0	966, 966			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	-12, 309				8. 00
9.00	00900 HOUSEKEEPI NG	0	360, 578			9.00
10.00	01000 DI ETARY	0	326, 619			10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	679, 838			13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	2, 007, 113			14.00
15. 00	01500 PHARMACY	0	550, 382			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	417, 110			16.00
17. 00	01700 SOCIAL SERVICE	0	35, 524			17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-1, 420	2, 405, 370			30.00
30.00	ANCI LLARY SERVICE COST CENTERS	-1, 420	2, 405, 370			30.00
50. 00	05000 OPERATING ROOM	-60	8, 717, 897			50.00
51. 00	05100 RECOVERY ROOM	-00	0,717,897			51.00
53. 00	05300 ANESTHESI OLOGY	245, 375	1			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	243, 373	370, 124			54.00
54. 01	05401 ULTRASOUND	0	0,0,121			54. 01
57. 00	05700 CT SCAN	0	l ol			57. 00
58. 00	05800 MRI	0	0			58. 00
60. 00	06000 LABORATORY	0	319, 530			60.00
65. 00	06500 RESPI RATORY THERAPY	0	13, 447			65. 00
66.00	06600 PHYSI CAL THERAPY	0	2, 158, 535			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	O			67. 00
68.00	06800 SPEECH PATHOLOGY	0	o			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	19, 299			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	446, 280			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 489, 547			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 312, 025			73. 00
	OUTPATIENT SERVICE COST CENTERS					
91. 00	09100 EMERGENCY	0	0			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. 00
	OTHER REIMBURSABLE COST CENTERS	_				
95. 00	09500 AMBULANCE SERVI CES	0	0			95. 00
	SPECIAL PURPOSE COST CENTERS	1				
118.00		-23, 406, 171	47, 005, 092			118. 00
100.00	NONREI MBURSABLE COST CENTERS	_	44 44			100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	44, 146			192.00
	19300 NONPALD WORKERS	0	0			193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS 07951 SPORTS MARKETING	0	1			194. 00 194. 01
	07951 SPORTS MARKETING		1, 036, 994 812, 490			194. 01
	07952 MARKETING 07953 OTHER NONREIMBURSABLE COST CENTERS		812, 490			194. 02
200.00	1 1	-23, 406, 171	1			200. 00
200.00	TOTAL (SOM OF LINES 110-177)	25,400,171	1 70,070,122			1200.00

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150168

					5/31/2016	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>1, 652, 348</u>		1. 00
	U CONTENT COSTS		U <sub></sub>	1, 652, 348		
1. 00	B - OXYGEN COSTS MEDICAL SUPPLIES CHARGED TO	71. 00	ol	44, 234		1 00
1.00	PATIENT	71.00	U	44, 234		1. 00
		+		44, 234		
	C - RENTAL & LEASE EXPENSES		<u> </u>	11, 201		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 472, 495		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	447, 683		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192, 00	o	940		3.00
4.00		0.00	0	0		4.00
5. 00		0.00	o	0		5. 00
6.00		0.00	o	0		6, 00
7.00		0.00	o	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	o	0		10.00
				3, 921, 118		
	D - OTHER CAPITAL COSTS	· · · · · · · · · · · · · · · · · · ·	-1			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	84, 450		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	o	321, 334		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	6, 154		3.00
				411, 938		
	E - MARKETING DEPARTMENT	•				
1.00	MARKETI NG	194. 02	101, 253	711, 237		1.00
		- $  -$	101, 253	711, 237		
	F - CNO COSTS					
1.00	NURSING ADMINISTRATION	13. 00	162, 376	0		1. 00
			162, 376	— — <u>o</u>		1
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	402, 046		1. 00
	PATI ENT					
2.00	IMPL. DEV. CHARGED TO	72. 00	0	13, 489, 547		2. 00
	PATI ENTS					
3.00	OPERATING ROOM	5000	•	7 <u>4, 2</u> 91		3. 00
	0		0	13, 965, 884		
	H - DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS		•	<u>1, 312, 0</u> 25		1. 00
	0		0	1, 312, 025		
	I - RECLASS OF PT, OT, ST COSTS					
1.00	PHYSI CAL THERAPY	66. 00	123, 973	9, 151		1. 00
2.00		0.00	•	0		2. 00
	0		123, 973	9, 151		
	J - OTHER RADIOLOGY COSTS					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	78, 601	31, 642		1. 00
2.00		0. 00	0	0		2. 00
3.00		0.00		0		3. 00
	0		78, 601	31, 642		
4 60	K - OTHER MI SCELLANEOUS	=a as1	4 404 74.1	600 45:1		
1.00	OPERATI NG_ROOM	5000	<u>1, 191, 716</u>	382, 456		1. 00
	U ARMAN OTRATIANS	DE01.400	1, 191, 716	382, 456		
	L - ADMINISTRATIVE AND GENERAL		00.4 ===-			
1. 00	ADMI TTI NG		894, 500	69 <u>7, 6</u> 5 <u>7</u>		1. 00
F00 00	U Constant Table 1		894, 500	697, 657		F00 00
500.00	Grand Total: Increases		2, 552, 419	23, 139, 690		500. 00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150168

						5/31/201	e Prepared: 6 10:23 am
		Decreases		<b>'</b>	<u>'</u>		- 10. 20 a
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE AND	5. 02	0	1, 652, 348	(	0	1. 00
	GENERAL-OTHER					_	
	0		0	1, 652, 348			
	B - OXYGEN COSTS				1		
1.00	ANESTHESI OLOGY	53. 00	•	4 <u>4, 2</u> 34		<u>이</u>	1. 00
	0		0	44, 234			
	C - RENTAL & LEASE EXPENSES						
1.00	ADMINISTRATIVE AND	5. 02	0	2, 407, 712		9	1. 00
	GENERAL-OTHER						
2.00	NURSING ADMINISTRATION	13. 00	0	176		9	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	41, 961		0	3. 00
4.00	PHARMACY	15. 00	0	40, 644		0	4. 00
5.00	MEDICAL RECORDS & LIBRARY	16. 00	0	4, 094		0	5. 00
6.00	OPERATING ROOM	50.00	0	891, 704		0	6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	77, 483		0	7. 00
8.00	PHYSI CAL THERAPY	66. 00	0	417, 012	!	0	8. 00
9.00	OPERATION OF PLANT	7. 00	0	2, 192		0	9. 00
10.00	SPORTS MARKETING	194. 01	0_	3 <u>8, 1</u> 40	(	<u>o</u>	10.00
	0		0	3, 921, 118			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE AND	5. 02	0	411, 938	1:	2	1. 00
	GENERAL-OTHER						
2.00		0.00	0	0			2. 00
3.00		0.00	0	0	1:	2	3. 00
	0		0	411, 938			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE AND	5. 02	101, 253	711, 237	(	0	1. 00
	GENERAL-OTHER						
	0		101, 253	711, 237			
	F - CNO COSTS						
1.00	ADMINISTRATIVE AND	5. 02	162, 376	0	)	0	1. 00
	GENERAL-OTHER						
	0		162, 376	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	13, 851, 754	. (	0	1. 00
2.00	LABORATORY	60.00	0	114, 130	)	0	2. 00
3.00		0.00	0	0		0	3. 00
	0		o	13, 965, 884			
	H - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	<u>15.</u> 00	0	<u>1, 312, 0</u> 25		<u>o</u>	1. 00
	0		0	1, 312, 025			
	I - RECLASS OF PT, OT, ST COSTS						
1.00	OCCUPATI ONAL THERAPY	67. 00	123, 881	9, 144	. (	0	1.00
2.00	SPEECH PATHOLOGY	6800	92			0	2. 00
	0		123, 973	9, 151			
	J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54. 01	0	4, 183	(	0	1. 00
2.00	CT SCAN	57. 00	0	4, 160	)	0	2. 00
3.00	MRI	58. 00	78, 601	23, 299	(	0	3. 00
	0		78, 601	31, 642			
	K - OTHER MI SCELLANEOUS	<u>'</u>					
1.00	RECOVERY ROOM	51.00	1, 191, 716	382, 456	(	0	1.00
		+	1, 191, 716	382, 456		7	
	L - ADMINISTRATIVE AND GENERAL	RECLASS			•		
1.00	ADMINISTRATIVE AND	5. 02	894, 500	697, 657		0	1.00
	GENERAL-OTHER	]	.,	,			
			894, 500	697, 657		7	
	Grand Total: Decreases			23, 139, 690			

TAL CENTER In Lieu of Form CMS-2552-10
Provider CCN: 150168 | Period: | Worksheet A-7 | From 01/01/2015 | Part I

					From 01/01/2015 To 12/31/2015		pared:
						5/31/2016 10:	23 am_
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	0	0		0	0	1. 00
2.00	Land Improvements	26, 765	0	(	0	0	2. 00
3.00	Buildings and Fixtures	2, 164, 253	509, 407	(	0 509, 407	2, 290	3. 00
4.00	Building Improvements	10, 673, 794	733, 155	(	0 733, 155	264, 019	4. 00
5.00	Fi xed Equi pment	0	0		0	0	5. 00
6.00	Movable Equipment	0	0		0	0	6. 00
7.00	HIT designated Assets	202, 081	0		0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	13, 066, 893	1, 242, 562		0 1, 242, 562	266, 309	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	13, 066, 893	1, 242, 562		0 1, 242, 562	266, 309	10.00
		Endi ng Bal ance	Fully		<u> </u>		
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	0				1. 00
2.00	Land Improvements	26, 765	0				2. 00
3.00	Buildings and Fixtures	2, 671, 370	0				3. 00
4.00	Building Improvements	11, 142, 930	0				4. 00
5.00	Fi xed Equi pment	O	0				5. 00
6.00	Movable Equipment	o	0				6. 00
7.00	HIT designated Assets	202, 081	0				7. 00
8.00	Subtotal (sum of lines 1-7)	14, 043, 146	0				8. 00
9.00	Reconciling Items	0	o				9. 00
10.00	Total (line 8 minus line 9)	14, 043, 146	0				10.00

∐oal +k	n Financial Systems LU	JTHERAN MUSCULO:	CVELETAL CENTER	<b>.</b>	In Lie	eu of Form CMS-:	2552 10
	CILIATION OF CAPITAL COSTS CENTERS	JITEKAN WUSCULU		CCN: 150168	Peri od:	Worksheet A-7	
KECUN	CILIATION OF CAPITAL COSTS CENTERS		Provider	CCN: 150168	From 01/01/2015		
					To 12/31/2015		nared:
					12, 01, 2010	5/31/2016 10:	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	42, 859	0	)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 119, 782	0	)	0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 162, 641	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	42, 859	1			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 119, 782	1			2. 00
	1			1			

0 0 0

42, 859 1, 119, 782 1, 162, 641

1. 00 2. 00 3. 00

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

Provider CN: 150168	Heal th	Financial Systems LU	THERAN MUSCULO	SKELETAL CENTER	?	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIOS   ALLOCATION OF OTHER CAPITAL	RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der		From 01/01/2015	Part III Date/Time Pre	pared:
Leases   For Ratio     Instructions			COM	PUTATION OF RAT	TI OS	ALLOCATION OF		20 4
PART   II - RECONCILIATION OF CAPITAL COSTS CENTERS		Cost Center Description	Gross Assets		for Ratio (col. 1 - col	instructions)	Insurance	
1.00   CAP REL COSTS-BLDG & FIXT   675,029   0 675,029   0.048068   0 2.00   2.00   CAP REL COSTS-MVBLE EQUIP   13,368,118   0 13,368,118   0.951932   0 2.00   3.00   Total (sum of lines 1-2)   14,043,147   0 14,043,147   1.000000   0 3.00   Cost Center Description				2.00	3.00	4. 00	5. 00	
2. 00   CAP REL COSTS-MVBLE EQUIP   13, 368, 118   0   13, 368, 118   0   14, 043, 147   1. 000000   0   3. 00								
Total (sum of lines 1-2)				l .	·			
ALLOCATION OF OTHER CAPITAL   SUMMARY OF CAPITAL				l .				
Taxes	3.00	Total (sum of lines 1-2)						3. 00
Capital -Relate   Cols. 5   through 7				ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
A Costs   through 7)		Cost Center Description	Taxes	Other		Depreciation	Lease	
CAP REL COSTS-BLDG & FIXT   O   O   O   O   S, 275, 896   -2, 720, 883   1.00				Capi tal -Relate	cols. 5	·		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				d Costs	through 7)			
1.00				7. 00	8. 00	9. 00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 1,741,028 0 2.00 0 0 5,275,896 -2,720,883 3.00    SUMMARY OF CAPITAL  Cost Center Description Interest Insurance (see instructions) Capital -Relate of Costs (see instructions) Instructions (see instructions) Capital -Relate of Costs (see instructions) Insurance (see instructions) Instructions (see instructions)			ENTERS					
3.00   Total (sum of lines 1-2)	1.00		0	0		0 3, 534, 868	-2, 720, 883	1. 00
SUMMARY OF CAPITAL   Cost Center Description   Interest   Insurance (see instructions)   Instructions   Instr	2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 741, 028	0	2. 00
Cost Center Description  Interest Insurance (see instructions)   Taxes (see instructions)   Total (2) (sum of cols. 9 d Costs (see instructions)   Interest Insurance (see instructions)   Instructions (see instr	3.00	Total (sum of lines 1-2)	0	0			-2, 720, 883	3. 00
instructions   instructions   Capital -Relate   d Costs (see   instructions   line   Costs   line   Costs   line   Costs   line   Costs   line   li				Sl	JMMARY OF CAPI	TAL		
d Costs (see instructions)   11.00   12.00   13.00   14.00   15.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
Instructions				instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
11. 00 12. 00 13. 00 14. 00 15. 00  PART III - RECONCILIATION OF CAPITAL COSTS CENTERS  1. 00 CAP REL COSTS-BLDG & FIXT 0 84, 450 321, 334 0 1, 219, 769 1. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 6, 154 0 0 1, 747, 182 2. 00						d Costs (see	through 14)	
PART       - RECONCILIATION OF CAPITAL COSTS CENTERS						instructions)		
1. 00     CAP REL COSTS-BLDG & FIXT     0     84, 450     321, 334     0     1, 219, 769     1. 00       2. 00     CAP REL COSTS-MVBLE EQUIP     0     6, 154     0     0     1, 747, 182     2. 00				12.00	13.00	14. 00	15. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 6, 154 0 0 1, 747, 182 2.00			1					
			-					
3.00   Total (sum of lines 1-2)   0  90,604  321,334  0  2,966,951  3.00						-		
	3.00	Total (sum of lines 1-2)	0	90, 604	321, 33	4 0	2, 966, 951	3.00

 TAL CENTER
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150168
 Period: From 01/01/2015
 Worksheet A-8

 From 01/01/2015
 To 12/31/2015
 Date/Time Prepared:

				Ť.	o 12/31/2015	Date/Time Prep 5/31/2016 10:2	pared:
	,			Expense Classification on		3/31/2010 10.2	zs alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 0	1. 00
0.00	COSTS-BLDG & FIXT (chapter 2)			DAR DEL COCTO MAIDLE FOLLID	2 22		0.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		U		0. 00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)	A	-8, 191	CAP REL COSTS-MVBLE EQUIP	2. 00	9	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-28, 396	3		0	10. 00
11. 00	Sale of scrap, waste, etc.		0	D	0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-3, 759, 149			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15. 00	Rental of quarters to employee and others	:	0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts		-				
19. 00	Nursing school (tuition, fees, books, etc.)		U		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		· ·		0.00	Ŭ	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	A	363	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL	A	97, 050	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	U	JOSSI ATTONAL THERAFT	67.00		30.00
30. 99	Hospice (non-distinct) (see		Ō	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	4.0.2					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest						
33. 00	RENTAL INCOME	B	-4, 441	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 00

				'	0 12/31/2013	5/31/2016 10:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
34.00	OTHER MISC REVENUE	В	-15, 008	ADMINISTRATIVE AND	5. 02	0	34.00
				GENERAL-OTHER			
36.00	MI NORI TY I NTEREST	A	-19, 553, 685	ADMINISTRATIVE AND	5. 02	0	36.00
				GENERAL-OTHER			
37.00	SPECIAL EVENTS	A	-6, 280	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	37.00
38.00	MARKETING EXPENSE	A	-2, 391	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	38. 00
39.00	MARKETING EXPENSE	Α	-10, 031	ADMINISTRATIVE AND	5. 02	0	39. 00
				GENERAL-OTHER			
40.00	PENALTI ES	A	-386	ADMINISTRATIVE AND	5. 02	0	40.00
				GENERAL-OTHER			
41.00	CHARITABLE CONTRIBUTIONS	A	-17, 818	ADMINISTRATIVE AND	5. 02	0	41.00
				GENERAL-OTHER			
43.00	WORLD BASEBALL ACADEMY RENT	A	-19, 070	ADMINISTRATIVE AND	5. 02	0	43.00
				GENERAL-OTHER			
44.00			0		0.00	0	44. 00
45.00	PHYSICIAN RECRUITING	A	-76, 806	ADMINISTRATIVE AND	5. 02	0	45. 00
				GENERAL-OTHER			
46.00	LOBBYING EXPENSES	A		ADMINISTRATIVE AND	5. 02	0	46. 00
				GENERAL-OTHER			
50.00	TOTAL (sum of lines 1 thru 49)		-23, 406, 171				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

<sup>|</sup> column 6, line 200.) | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

<sup>(2)</sup> 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.

					5/31/2016 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	0.00	2.00	4.00	5	
	1.00	2.00	3.00	4.00	5. 00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL - BLDG & FIXTUR	6, 258	0	1. 00
2. 00	l control of the cont	ADMINISTRATIVE AND GENERAL-O	II	110, 551	-25, 539	
3. 00	l control of the cont	ADMITTING	PASI FEES	97, 946	·	
3. 01	1	CAP REL COSTS-MVBLE EQUIP	NEW CAP- MOVEABLE	69, 290	·	3. 01
3. 02	l control of the cont	ADMINISTRATIVE AND GENERAL-O	l e	999, 646		3. 02
3. 03	l control of the cont	l .	PRE-ACQUISITION LEGACY CAPIT	2, 456		3. 03
3. 04		CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL - MOVEABLE	914	O	3. 04
3. 05		CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION LEGACY CAPIT	14, 500	O	3. 05
3.06	5. 02	ADMINISTRATIVE AND GENERAL-O	PRE-ACQUISITION PERIOD NON-C	150, 655	0	3. 06
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAP - BLDG & FIXTURES	10, 437	O	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	FWO SURGERY CENTER	171, 577	656, 744	4. 01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS MRI	14, 713	72, 181	4. 02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS PT	95, 034	287, 707	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS PT	123, 702	161, 700	4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	TOH RENT/LUTHERAN	440, 840	2, 383, 976	4. 05
4.06	8. 00	LAUNDRY & LINEN SERVICE	TOH LAUNDRY & LINEN	81, 719	94, 028	4. 06
4.07	5. 02	ADMINISTRATIVE AND GENERAL-O	TOH MGT FEES	0	1, 698, 075	4. 07
4.08	0. 00			0	0	4. 08
5.00	0		0	2, 390, 238	6, 149, 387	5. 00

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

			Related Organization(s) and	/or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
Symbol (1)	Name	Ownershi p	Name	Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	COMMUNITY HEALT	60.00 COMMUNITY HEALT	60. 00	6. 00
7.00	В	LUTHERAN HEALTH	40.00 LUTHERAN HEALTH	40. 00	7.00
8.00	В	HOSPI TAL LAUNDR	100.00 HOSPITAL LAUNDR	100. 00	8.00
9.00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

4 03

4.04

4.05

4.06

4 07

4.08

5.00

	ated Organization(s) nd/or Home Office		
	Type of Business		
	6. 00		
B. INT	ERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE		6. 00
7.00	HOSPI TAL		7.00
8.00	LAUNDRY SERVICE		8.00
9.00			9. 00
10.00			10.00
100.00		10	100. 00

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

10

10

10

0

0

0

4 03

4.04

4.05

4.06

4 07

4.08

5.00

-192, 673

-1, 943, 136

-1, 698, 075

-37, 998

-12, 309

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 150168

					'	12/31/2013	5/31/2016 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·			Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	30.00	ADULTS & PEDIATRICS	1, 420	1, 420	0	171, 400	0	1. 00
2.00	5. 02	ADMINISTRATIVE AND	273, 868	270, 837	3, 031	136, 700	24	2. 00
		GENERAL-OTHER						
3.00	50. 00	OPERATING ROOM	60	60	0	204, 100	0	3. 00
4.00	53. 00	ANESTHESI OLOGY	-245, 375	-245, 375	0	200, 300	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	l o	0	O	l 0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			29, 973	26, 942	3, 031		24	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1. 00
2.00	5. 02	ADMINISTRATIVE AND	1, 577	79	0	0	0	2. 00
		GENERAL-OTHER	·					
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3. 00
4.00	53.00	ANESTHESI OLOGY	0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	l 0	0	0	l 0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 577	79	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1, 420		1. 00
2.00	5. 02	ADMINISTRATIVE AND	0	1, 577	1, 454	272, 291		2. 00
		GENERAL-OTHER						
3.00	50. 00	OPERATING ROOM	0	0	0	60		3. 00
4.00	53. 00	ANESTHESI OLOGY	0	0	0	-245, 375		4. 00
5.00	0.00		0	0	0	0		5. 00
6.00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10. 00
200.00			0	1, 577	1, 454	28, 396		200. 00

Heal th	Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		eri od:	Worksheet B	
					om 01/01/2015	Part I	
				To	12/31/2015	Date/Time Pre 5/31/2016 10:	pared:
			CADITAL DEL	ATED COSTS		3/31/2010 10.	23 alli
			CAFITAL KLI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
	cost center bescription	for Cost	DLUG & FIAI	WIVELE EQUIP	BENEFITS	ADMITTING	
		Allocation					
					DEPARTMENT		
		(from Wkst A					
		col . 7)	1 00	2.00	4.00	F 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	4. 00	5. 01	
1 00		1 210 7/0	1 010 7/0				1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 219, 769					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 747, 182	l	1, 747, 182			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 729, 938	l	0	1, 729, 938		4. 00
5. 01	00570 ADMI TTI NG	1, 541, 031		8, 563	125, 249	1, 680, 821	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL-OTHER	6, 099, 844	25, 361	36, 326	159, 673	0	5. 02
7.00	00700 OPERATION OF PLANT	966, 966	705, 992	1, 011, 254	6, 650	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	71, 144	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	360, 578	0	0	0	0	9. 00
10.00	01000 DI ETARY	326, 619	ł	0	ol	0	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	679, 838	ł	0	39, 649	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 007, 113	ł	o o	45, 680	0	14. 00
15. 00	01500 PHARMACY	550, 382	ł .	0	43, 000	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		l e	0	0	0	16. 00
	01700 SOCIAL SERVICE	417, 110		0	- 1	-	
17. 00		35, 524	U	0	0	0	17. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 405 070	000 074	20/ 0/5	074 070	24.077	00.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 405, 370	200, 271	286, 865	274, 970	34, 866	30. 00
	ANCILLARY SERVICE COST CENTERS	0 747 007	400 045	00/ 040	/FF 340	010 50/	
50. 00	05000 OPERATI NG ROOM	8, 717, 897	199, 815		655, 719	812, 506	
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400   RADI OLOGY-DI AGNOSTI C	370, 124	0	0	16, 489	51, 581	54. 00
54. 01	05401 ULTRASOUND	0	0	0	0	0	
57.00	05700 CT SCAN	0	0	0	0	0	
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	319, 530	0	0	689	18, 501	60.00
65.00	06500 RESPI RATORY THERAPY	13, 447	0	0	0	1, 318	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 158, 535	0	0	262, 269	69, 631	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	19, 299	0	0	10	3, 722	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	446, 280	82, 352	117, 961	0	76, 979	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 489, 547	1	0	o	497, 362	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 312, 025		0	o	114, 355	1
	OUTPATIENT SERVICE COST CENTERS				-1		
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ		Ĭ	ŭ	92. 00
, 2. 00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>		75.00
118. 00		47, 005, 092	1, 219, 769	1, 747, 182	1, 587, 047	1, 680, 821	110 00
110.00		47,000,092	1, 217, 707	1, 747, 102	1, 567, 047	1, 000, 021	1110.00
102.00	NONREI MBURSABLE COST CENTERS   19200   PHYSI CI ANS' PRI VATE OFFI CES	44, 146		_	254	0	192. 00
		44, 140	l e	0	256		
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
	07951 SPORTS MARKETING	1, 036, 994	l	0	128, 457		194. 01
	07952 MARKETI NG	812, 490	0	0	14, 178		194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 03
200.00							200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	48, 898, 722	1, 219, 769	1, 747, 182	1, 729, 938	1, 680, 821	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150168 Peri od: From 01/01/2015

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0

0

0

0 91.00

0

92.00

95.00

Worksheet B Part I 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am Cost Center Description Subtotal ADMI NI STRATI VE OPERATION OF LAUNDRY & HOUSEKEEPI NG LINEN SERVICE AND **PLANT** GENERAL-OTHER 5A. 01 7.00 8. 00 9. 00 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00590 ADMINISTRATIVE AND GENERAL-OTHER 6, 321, 204 6, 321, 204 5.02 5.02 2, 690, 862 7.00 00700 OPERATION OF PLANT 399, 493 3, 090, 355 7.00 00800 LAUNDRY & LINEN SERVICE 81, 706 10, 562 8.00 71.144 C 8 00 9.00 00900 HOUSEKEEPI NG 360, 578 53, 532 414, 110 9.00 10.00 01000 DI ETARY 326, 619 48, 491 0 0 0 10.00 01300 NURSING ADMINISTRATION 719.487 106, 817 13.00 13.00 0 0 0 01400 CENTRAL SERVICES & SUPPLY 2, 052, 793 0 14.00 304, 764 0 0 14.00 15.00 01500 PHARMACY 550, 382 81, 711 0 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 417, 110 61, 925 0 0 16.00 01700 SOCIAL SERVICE 17.00 35, 524 0 5, 274 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 202, 342 475, 429 1, 282, 873 66, 144 171, 906 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1, 279, 957 15, 562 171, 515 50.00 10, 672, 150 1, 584, 419 51.00 05100 RECOVERY ROOM 0 51.00 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 438, 194 65, 056 0 54.00 54.00 0 05401 ULTRASOUND 0 54.01 0 C 0 54.01 57.00 05700 CT SCAN 0 C 0 0 0 57.00 05800 MRI 58.00 0 0 0 0 0 58.00 60 00 06000 LABORATORY 338.720 50. 287 0 60 00 0 06500 RESPIRATORY THERAPY 0 65.00 14, 765 2, 192 0 65.00 06600 PHYSI CAL THERAPY 2, 490, 435 369, 737 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 67.00 0 C 06800 SPEECH PATHOLOGY 0 68.00 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 23, 031 3, 419 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 107, 424 0 70, 689 71.00 723, 572 527, 525 71.00 οĺ 13, 986, 909 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,076,559 0 72.00 C 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 426, 380 211, 765 0 0 73.00 OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 3, 090, 355 118.00 46, 862, 201 6, 018, 856 81, 706 414, 110 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 44, 402 6, 592 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 0 C 194. 01 07951 SPORTS MARKETING 1, 165, 451 173, 026 0 0 0 194. 01 194. 02 07952 MARKETI NG 826, 668 122, 730 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 03 0 0 C 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118-201) 48, 898, 722 6, 321, 204 3, 090, 355 81, 706 414, 110 202. 00

0

0

0

91.00

92.00

95.00

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150168

			То	12/31/2015	Date/Time Pre 5/31/2016 10:	
Cost Center Description	DI ETARY	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	23 alli
oust content beson per on	DI E IANKI	ADMI NI STRATI ON	SERVICES &	111111111111111111111111111111111111111	RECORDS &	
			SUPPLY		LI BRARY	
	10.00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	1	1				
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUI P						2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01   00570   ADMI TTI NG						5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL-OTHER						5. 02
7. 00   00700   OPERATION OF PLANT						7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG	275 110					9.00
10. 00   01000   DI ETARY	375, 110	1				10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	· · · · · ·	020,001	2 257 557			13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	0		2, 357, 557	632, 093		14. 00 15. 00
	1	, o	J	032, 093	479, 035	16.00
	0	, o	0	0		
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	U	y U	U	······································	0	17. 00
30. 00 03000 ADULTS & PEDIATRICS	375, 110	244, 129	26, 074	ol	9, 935	30.00
ANCI LLARY SERVI CE COST CENTERS	070,110	211,127	20,071	<u> </u>	7, 700	00.00
50. 00 05000 OPERATI NG ROOM	0	582, 175	443, 408	0	231, 619	50.00
51.00 05100 RECOVERY ROOM	0	o	0	O	0	51.00
53. 00   05300   ANESTHESI OLOGY	0	ol ol	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	1, 338	0	14, 697	54.00
54. 01   05401   ULTRASOUND	0	0	0	0	0	54. 01
57. 00  05700 CT SCAN	0	0	0	0	0	57. 00
58. 00   05800   MRI	0	0	0	0	0	58. 00
60. 00   06000   LABORATORY	0	0	809	0	5, 272	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	375	65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	17, 348	0	19, 841	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00  06900   ELECTROCARDI OLOGY	0	0	0	0	1, 061	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	이	59, 758	0	21, 934	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 806, 281	0	141, 717	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	632, 093	32, 584	73. 00
OUTPATIENT SERVICE COST CENTERS		ا		ما		
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 O9500 AMBULANCE SERVICES	0	ol	0	o	0	95. 00
SPECIAL PURPOSE COST CENTERS		<u>′</u> 1	<u> </u>	<u> </u>		75.00
118.00   SUBTOTALS (SUM OF LINES 1-117)	375, 110	826, 304	2, 355, 016	632, 093	479, 035	118. 00
NONREI MBURSABLE COST CENTERS		,	,	, , , , ,	, , , , , , , , , , , , , , , , , , , ,	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	89	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	이	0	0	0	
194.01 07951 SPORTS MARKETING	0	이	2, 197	0		194. 01
194. 02 07952 MARKETI NG	0	이	255	0		194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	이	0	0	0	1., 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	375, 110	826, 304	2, 357, 557	632, 093	479, 035	J202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150168 Peri od: Worksheet B From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am Cost Center Description SOCIAL SERVICE Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5. 01 5.01 00590 ADMINISTRATIVE AND GENERAL-OTHER 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 40, 798 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 40, 798 0 30.00 30.00 5, 894, 740 5, 894, 740 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 980, 805 0 14, 980, 805 50.00 0 05100 RECOVERY ROOM 51.00 0 51.00 0 0 0 05300 ANESTHESI OLOGY 0 53 00 53 00 O 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 519, 285 519, 285 54.00 05401 ULTRASOUND 54.01 54.01 57.00 05700 CT SCAN 0000000000 0 0 0 57.00 0 05800 MRI 58 00 58 00 0 06000 LABORATORY 60.00 395, 088 395, 088 60.00 06500 RESPIRATORY THERAPY 17, 332 0 65.00 17, 332 65.00 2, 897, 361 06600 PHYSI CAL THERAPY 0 2, 897, 361 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 C 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 27, 511 0 69 00 27, 511 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 510, 902 1, 510, 902 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 18, 011, 466 72 00 18, 011, 466 72 00 07300 DRUGS CHARGED TO PATIENTS 2, 302, 822 2, 302, 822 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 40, 798 46, 557, 312 0 46, 557, 312 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 0 51,083 0 51, 083 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194.00 0 0 194. 01 07951 SPORTS MARKETING 1, 340, 674 1, 340, 674 194. 01 194. 02 07952 MARKETI NG 0 194 02 949, 653 949, 653 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 03 0

0

0

48, 898, 722

40, 798

0

0

48, 898, 722

200. 00

201. 00

202. 00

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150168

				10	12/31/2015	Date/lime Pre   5/31/2016 10:	
			CAPI TAL REI	LATED COSTS		3/31/2010 10.	25 4111
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	T					1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 01	00570 ADMITTING	0	5, 978	8, 563	14, 541	0	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL-OTHER	0	25, 361	36, 326	61, 687	0	5. 02
7.00	00700 OPERATION OF PLANT	0	705, 992	1, 011, 254	1, 717, 246	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	0	0	9. 00
10.00	01000 DI ETARY	0	0	-	0	0	10.00
13. 00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17. 00	01700 SOCIAL SERVICE	] 0	0	0	0	0	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	200, 271	286, 865	487, 136	0	30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS		200, 271	200, 000	407, 130	0	30.00
50. 00	05000 OPERATING ROOM	0	199, 815	286, 213	486, 028	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
53. 00	05300 ANESTHESI OLOGY	0	Ö		o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	O	0	O	0	54.00
54. 01	05401 ULTRASOUND	0	0	О	0	0	54. 01
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	0	0	-	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	_	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	-	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	-	0	0	68. 00
69. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	02 252	117 0/1	0	0	69. 00 71. 00
71. 00 72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	82, 352 0		200, 313 0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			ol	0	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	<u> </u>	0	73.00
91. 00	09100 EMERGENCY	0	0	O	O	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ		Ö	ū	92.00
	OTHER REIMBURSABLE COST CENTERS				-,		
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	,	0	1, 219, 769	1, 747, 182	2, 966, 951	0	118. 00
	NONREI MBURSABLE COST CENTERS	,					
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		192. 00
	19300 NONPALD WORKERS	0	0		0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	-	0		194. 00
	07951 SPORTS MARKETING	0		0	0		194. 01
	07952 MARKETI NG	0	0	0	0		194. 02 194. 03
200.00	07953 OTHER NONREIMBURSABLE COST CENTERS Cross Foot Adjustments				0	0	194. 03 200. 00
200.00	1 1		_		ol Ol	0	200.00
201.00	1 1 0	0	1, 219, 769	1, 747, 182	2, 966, 951		201.00
202.00	1.01/1E (30m 11/103 110 201)	1	1,217,707	1, 177, 102	2, 700, 751	O	1-02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				_	0 12/31/2015	Date/Time Pre 5/31/2016 10:	
	Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	20 4111
	·		AND	PLANT	LINEN SERVICE		
			GENERAL-OTHER				
	ASSUEDAN ASSUMAN ASSUTEDA	5. 01	5. 02	7. 00	8. 00	9. 00	
4 00	GENERAL SERVICE COST CENTERS	I	1				4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
2.00 4.00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING	14, 541					5. 01
5. 01	00570 ADMINISTRATIVE AND GENERAL-OTHER	14, 541	41 407				5. 01
7. 00	00700 OPERATION OF PLANT		61, 687 3, 899	1			7.00
8.00	00800 LAUNDRY & LINEN SERVICE		103		103		8.00
9. 00	00900 HOUSEKEEPING		522			522	9.00
10. 00	01000 DI ETARY		473		0	0	10.00
13. 00	01300 NURSING ADMINISTRATION		1, 043		0	0	
14. 00	01400 CENTRAL SERVI CES & SUPPLY		2, 974	0	0	0	14. 00
15. 00	01500 PHARMACY		798	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		604	ĺ	0	0	1
17. 00	01700 SOCIAL SERVICE		51	0	0	Ö	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>		J		17.00
30. 00	03000 ADULTS & PEDI ATRI CS	301	4, 640	714, 485	83	217	30. 00
	ANCILLARY SERVICE COST CENTERS		.,,,,,,	1			
50.00	05000 OPERATI NG ROOM	7, 038	15, 464	712, 860	20	216	50.00
51.00	05100 RECOVERY ROOM	0	0			0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	446	635	0	0	0	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800  MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	160	491	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	11	21	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	602	3, 609	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	32	33	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	665		293, 800	0	89	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 298	20, 261	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	988	2, 067	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	1	1				
91.00	09100 EMERGENCY	0	0	0	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	1	1				
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
110 00	SPECIAL PURPOSE COST CENTERS	14 541	F0.72/	1 701 145	100	F22	110 00
118.00		14, 541	58, 736	1, 721, 145	103	522	118. 00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES		64	0	0		192. 00
	19300 NONPALD WORKERS				_		192.00
	07950 OTHER NONREIMBURSABLE COST CENTERS		0				193.00
	07951 SPORTS MARKETING		1, 689		0		194. 00
	07951 SPORTS MARKETING		1, 198				194. 01
	07953 OTHER NONREIMBURSABLE COST CENTERS		1, 198		0		194. 02
200.00							200. 00
201.00	1 1	0	0	n	n	n	201.00
202.00	9	14, 541	61, 687	1, 721, 145	103		202.00
00	1 1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1, 511	3.,307	1,,2,,,10	.00	322	,

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150168

Peri od: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/31/2016 10:23 am Cost Center Description DI ETARY NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 10.00 13.00 15.00 14.00 16, 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00590 ADMINISTRATIVE AND GENERAL-OTHER 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 473 10.00 01300 NURSING ADMINISTRATION 1,043 13.00 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 2,974 14.00 r 14 00 15.00 01500 PHARMACY 0 0 C 798 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 604 16.00 01700 SOCIAL SERVICE 0 17.00 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 473 308 33 0 9 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 389 50.00 0 735 560 0 51.00 05100 RECOVERY ROOM 0 C C 0 0 51.00 05300 ANESTHESI OLOGY 53.00 0000000000000 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2 54.00 0 13 54.00 05401 ULTRASOUND 0 54.01 0 0 54.01 57.00 05700 CT SCAN 0 0 0 57.00 05800 MRI 58.00 0 0 0 58.00 60 00 06000 LABORATORY 0 1 60 00 5 06500 RESPIRATORY THERAPY 0 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 22 17 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 C 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 75 19 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 2, 278 123 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 798 28 73.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 0 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 798 118.00 473 1,043 2, 971 604 118, 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 0 0 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00 0 194. 01 07951 SPORTS MARKETING 0 0 3 0 0 194. 01 194. 02 07952 MARKETI NG 0 0 0 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 03 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118-201) 473 1, 043 2, 974 798 604 202. 00

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2015	
			T	o 12/31/2015	Date/Time Prepared: 5/31/2016 10:23 am
Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Total	9, 61, 2616 161 26 4
			Residents Cost		
			& Post		
			Stepdown		
			Adjustments		
	17. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS					
1.00 O0100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00   00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01   00570   ADMI TTI NG					5. 01
5.02 00590 ADMINISTRATIVE AND GENERAL-OTHER					5. 02
7.00   00700 OPERATION OF PLANT					7. 00
8.00   00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00   00900   HOUSEKEEPI NG					9. 00
10. 00  01000 DI ETARY					10. 00
13. 00   01300   NURSI NG ADMI NI STRATI ON					13. 00
14.00   01400   CENTRAL SERVICES & SUPPLY					14. 00
15. 00   01500   PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE	51				17. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	51	1, 207, 736	0	1, 207, 736	30.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	0	1, 223, 310	0	1, 223, 310	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	51. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	1, 096	0	1, 096	54. 00
54. 01  05401 ULTRASOUND	0	0	0	0	54. 01
57. 00  05700   CT   SCAN	0	0	0	0	57. 00
58. 00   05800   MRI	0	0	0	0	58. 00
60. 00   06000   LABORATORY	0	657		657	60. 00
65. 00 06500 RESPI RATORY THERAPY	이	32		32	65. 00
66. 00   06600   PHYSI CAL THERAPY	이	4, 250		4, 250	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	O	0	1	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	-   0	66	1	66	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	496, 009	1	496, 009	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	26, 960		26, 960	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	3, 881	0	3, 881	73. 00
OUTPATIENT SERVICE COST CENTERS			1	0	01.00
91. 00 09100 EMERGENCY	0	0	0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	'				92. 00
OTHER REIMBURSABLE COST CENTERS			1	0	05.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	F-1	2.0/2.007		2 0/2 007	110.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	51	2, 963, 997	0	2, 963, 997	118. 00
NONREI MBURSABLE COST CENTERS					102.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	64		64	192.00
193. 00 19300 NONPALD WORKERS	) y	0	0	0	193. 00 194. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	) y	1 (0)		1 (02	
194. 01 07951 SPORTS MARKETI NG 194. 02 07952 MARKETI NG		1, 692		1, 692	194. 01 194. 02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS		1, 198		1, 198	194. 02
1	۱	0		0	200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0	0	201. 00
202.00   TOTAL (sum lines 118-201)	51	2, 966, 951		2, 966, 951	
202.00    101AL (Suiii 111165 110-201)	1 21	Z, 700, 75 I	1	۷, ۶۵۵, ۶۵۱	J202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150168 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** ADMI TTI NG Reconciliation (SQUARE FEET) (SQUARE FEET) BENEFITS (GROSS DEPARTMENT CHARGES) (GROSS SALARI ES) 1.00 2.00 5. 01 5A. 02 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 104, 466 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 104, 466 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 354, 881 4.00 00570 ADMITTING 5 01 512 512 894, 500 415, 052, 353 5 01 00590 ADMINISTRATIVE AND GENERAL-OTHER 5.02 2, 172 2, 172 1, 140, 349 -6, 321, 204 5.02 7.00 00700 OPERATION OF PLANT 60, 464 60, 464 47, 492 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 8.00 0 C C 0 00900 HOUSEKEEPI NG 9 00 0 0 9 00 0 10.00 01000 DI ETARY 0 C 0 0 10.00 01300 NURSING ADMINISTRATION 0 283, 168 0 13.00 13.00 0 0 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 0 326, 235 0 01500 PHARMACY 15.00 Ω 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 152 17, 152 1, 963, 775 8, 608, 807 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 113 17, 113 4, 683, 042 200, 653, 595 n 50.00 05100 RECOVERY ROOM 51.00 51.00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 117, 764 12, 736, 040 0 54.01 05401 ULTRASOUND 54.01 C 0 57.00 05700 CT SCAN 0 57.00 0 0 0 58.00 05800 MRI 0 58.00 06000 LABORATORY 60.00 0 0 4, 924 4, 568, 087 60.00 65.00 06500 RESPIRATORY THERAPY 0 325, 327 65.00 06600 PHYSI CAL THERAPY 66.00 C 1, 873, 067 17, 192, 845 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 74 919, 054 69 00 69 00 0 Λ 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7,053 7,053 0 19, 007, 238 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 122, 805, 440 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 28, 235, 920 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 104, 466 104, 466 11, 334, 390 415, 052, 353 -6, 321, 204 118. 00 118.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 1,826 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00 194. 01 07951 SPORTS MARKETING 0 194. 01 Ω 917, 412 194. 02 07952 MARKETI NG 0 C 101, 253 0 0 194. 02 194. 03 07953 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 219, 769 1, 747, 182 1, 729, 938 1, 680, 821 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.004050 203.00 11.676230 16. 724887 0.140021 Cost to be allocated (per Wkst. B, 204. 00 204.00 14, 541 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000035 205.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150168 | Peri od: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepa

				To	12/31/2015	Date/Time Pre 5/31/2016 10:	pared: 23 am
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)			
		5. 02	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.32					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	OO570   ADMITTING   OO590   ADMINISTRATIVE   AND GENERAL-OTHER	42, 577, 518					5. 01 5. 02
7. 00	00700 OPERATION OF PLANT	2, 690, 862	41, 318				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	71, 144	1	1			8. 00
9.00	00900 HOUSEKEEPI NG	360, 578	0	0	41, 318		9. 00
10. 00	01000 DI ETARY	326, 619	0	0	0	,	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	719, 487	0	0	0	0	13.00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	2, 052, 793 550, 382	i e		0	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	417, 110	l e		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	35, 524	Ö	Ö	0	Ō	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 202, 342	17, 152	116, 497	17, 152	14, 151	30. 00
FO 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	10 (70 150	17 110	27 400	17 110		
50. 00 51. 00	05100 RECOVERY ROOM	10, 672, 150	17, 113 0	1	17, 113 0	l	50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	438, 194	Ö	o o	0	Ö	54. 00
54. 01	05401 ULTRASOUND	0	o	o	0	0	54. 01
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60. 00 65. 00	06000  LABORATORY  06500  RESPI RATORY   THERAPY	338, 720	l	0	0	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	14, 765 2, 490, 435	ł		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 470, 433	ĺ		0	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	O	o	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 031	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	723, 572		1	7, 053	l .	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	13, 986, 909	ł		0	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	1, 426, 380		ıl O	0	0	73.00
91. 00	09100 EMERGENCY	0	С	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	_		,			
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	40, 540, 997	41, 318	143, 905	41, 318	14, 151	110 00
110.00	NONREI MBURSABLE COST CENTERS	40, 340, 777	41, 310	143, 703	41, 310	14, 151	1110.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	44, 402	С	0	0	0	192. 00
	19300 NONPALD WORKERS	0	o	0	0	0	193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
	07951 SPORTS MARKETING	1, 165, 451			0		194. 01
	07952 MARKETING 07953 OTHER NONREIMBURSABLE COST CENTERS	826, 668	0	0	0		194. 02 194. 03
200.00				ή	U		200. 00
201.00	, ,						201. 00
202.00		6, 321, 204	3, 090, 355	81, 706	414, 110	375, 110	1
203. 00	1 ' ' '	0. 148463	74. 794400	0. 567777	10. 022508	26. 507667	203. 00
204.00	Cost to be allocated (per Wkst. B,	61, 687	ŀ		522		204. 00
205.00		0. 001449	41. 656058	0. 000716	0. 012634	0. 033425	205. 00
	11)		l	1		I	l

11001	Financial Systems LL	JIHERAN WUSCULUS	KELETAL CENTER	Κ	<u>In</u> _le	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1	
					To 12/31/2015	Date/Time Pre	pared:
			OF NEDAL	DUA BUA OV		5/31/2016 10:	23 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINI STRATION	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED		(GROSS	(112 0. 2.11.)	
		NRSI NG)	REQUIS.)		CHARGES)		
		13.00	14.00	15. 00	16.00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 01	OO4OO  EMPLOYEE BENEFITS DEPARTMENT   OO57O  ADMITTING	-					4. 00 5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL-OTHER						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	6, 646, 817					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	17, 606, 517				14.00
15.00	01500   PHARMACY   01600   MEDICAL RECORDS & LIBRARY	0	0	1, 312, 24			15. 00
16. 00 17. 00	01700 SOCIAL SERVICE	0	0	1	0 415, 052, 353 0 0	5, 939	16. 00 17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0		'	<u> </u>	3, 737	17.00
30. 00	03000 ADULTS & PEDIATRICS	1, 963, 775	194, 721		8, 608, 807	5, 939	30.00
	ANCI LLARY SERVI CE COST CENTERS	., ., ., .,	,		5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5	27.101	1
50.00	05000 OPERATI NG ROOM	4, 683, 042	3, 311, 410	)	200, 653, 595	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	)	0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	)	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 991		12, 736, 040	0	54. 00
54. 01	05401 ULTRASOUND	0	0		0	0	54. 01
57. 00	05700 CT SCAN	0	0		0	0	57. 00 58. 00
58. 00 60. 00	05800   MRI   06000   LABORATORY		6, 041	ή ;	0 4, 568, 087	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0, 041		325, 327	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	o o	129, 557	,	17, 192, 845	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	Ō	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	)	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	)	919, 054	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	446, 280		19, 007, 238	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	13, 489, 546	1	122, 805, 440	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 312, 24	4 28, 235, 920	0	73. 00
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	O	0	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	0 (	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		U	'l	J	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	0	0	)	0 0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	6, 646, 817	17, 587, 546	1, 312, 24	4 415, 052, 353	5, 939	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	661	1	0		192. 00
	19300 NONPALD WORKERS	0	0	1	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	17 407	1	0 0		194.00
	07951  SPORTS MARKETING  07952  MARKETING		16, 406 1, 904		0		194. 01 194. 02
	07953 OTHER NONREIMBURSABLE COST CENTERS	0	1, 704	1	0		194. 02
200.00			0	1	J	Ĭ	200.00
201.00	, ,						201. 00
202.00		826, 304	2, 357, 557	632, 09	3 479, 035	40, 798	202. 00
	Part I)						
203.00		1	0. 133903	III		6. 869507	
204.00	,,,	1, 043	2, 974	798	8 604	51	204. 00
20E 00	Part II)	0.000157	0.000170	0.000(0)	0 000001	0.000507	205 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000157	0. 000169	0. 00060	0. 000001	0. 008587	∠∪5. ∪∪
	1 7	ı		1	ı I	•	

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150168	Period: Worksheet C From 01/01/2015 Part I
		To 12/31/2015 Date/Time Prepared

				To 12/31/2015	Date/Time Pre 5/31/2016 10:	pared: 23 am_
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				.1 _1		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 894, 740		5, 894, 740	0	5, 894, 740	30. 00
ANCILLARY SERVICE COST CENTERS	14 000 005			-1 -1	44 000 005	
50. 00   05000   OPERATI NG ROOM	14, 980, 805		14, 980, 805	0	14, 980, 805	
51. 00   05100   RECOVERY ROOM	0		(		0	51.00
53. 00   05300   ANESTHESI OLOGY	0		[ (		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	519, 285		519, 285	0	519, 285	
54. 01   05401   ULTRASOUND	0		9		0	54. 01
57. 00   05700   CT   SCAN	0		9		0	57. 00
58. 00   05800   MRI	0		(		0	58. 00
60. 00 06000 LABORATORY	395, 088	•	395, 088		395, 088	
65. 00 06500 RESPIRATORY THERAPY	17, 332	0	17, 332		17, 332	
66. 00   06600   PHYSI CAL THERAPY	2, 897, 361	0	2, 897, 36	0	2, 897, 361	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	9		0	67.00
68. 00 06800 SPEECH PATHOLOGY	07.544	0	( )		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	27, 511		27, 51		27, 511	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 510, 902		1, 510, 902		1, 510, 902	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	18, 011, 466		18, 011, 466		18, 011, 466	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 302, 822		2, 302, 822	2  0	2, 302, 822	73. 00
OUTPATIENT SERVICE COST CENTERS				.1 _1		
91. 00   09100   EMERGENCY	0		(		0	1 ,
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	134, 809		134, 809	?	134, 809	92. 00
OTHER REIMBURSABLE COST CENTERS				.1 _1		
95. 00 09500 AMBULANCE SERVICES	0	_	(	0	0	
200.00 Subtotal (see instructions)	46, 692, 121	0	46, 692, 121		46, 692, 121	
201.00 Less Observation Beds	134, 809	_	134, 809		134, 809	
202.00 Total (see instructions)	46, 557, 312	0	46, 557, 312	의 이	46, 557, 312	J202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150168	Peri od:	Worksheet C

To 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpatient Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 285, 491 8, 285, 491 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 114, 620, 232 200, 653, 595 0.074660 0.000000 50.00 86, 033, 363 51.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 181, 252 8, 554, 788 12, 736, 040 0.040773 0.000000 54.00 54.01 05401 ULTRASOUND 0 0 0 0.000000 0.000000 54.01 05700 CT SCAN 0.000000 0.000000 57.00 57.00 0 C 0 58.00 05800 MRI 0.000000 0.000000 58 00 60.00 06000 LABORATORY 3, 566, 279 1,001,808 4, 568, 087 0.086489 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 282, 464 42, 863 325, 327 0.053276 0.000000 65.00 12, 712, 304 17, 192, 845 66.00 06600 PHYSI CAL THERAPY 4, 480, 541 66.00 0.168521 0.000000 67.00 06700 OCCUPATIONAL THERAPY C 0.000000 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 246,002 673, 052 919, 054 0.029934 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 10, 119, 611 19, 007, 238 0.079491 8, 887, 627 71 00 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 95, 769, 060 27, 036, 380 122, 805, 440 0.146667 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 16, 723, 746 11, 512, 174 28, 235, 920 0.081556 0.000000 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.000000 0.000000 91.00 48, 807 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 274, 509 323, 316 0.416957 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0.000000 0.000000 95.00 200.00 Subtotal (see instructions) 229, 736, 616 185, 315, 737 415, 052, 353 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 229, 736, 616 185, 315, 737 415, 052, 353 202.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150168	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/31/2016 10:23 am		

				5/31/2016 10: 23 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 074660			50.00
51.00   05100   RECOVERY ROOM	0. 000000			51.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 040773			54.00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
57.00   05700   CT   SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58. 00
60. 00   06000   LABORATORY	0. 086489			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 053276			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 168521			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 029934			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 079491			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 146667			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 081556			73. 00
OUTPATIENT SERVICE COST CENTERS	·			
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416957			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 150168	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/31/2016 10:23 am		

				1	o 12/31/2015	Date/Time Pre 5/31/2016 10:	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
	LABORT ENT. DOUTLAND OFFICE OF COOK OFFICE	1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 004 740	1	F 004 740		F 004 740	00.00
30. 00	03000 ADULTS & PEDIATRICS	5, 894, 740		5, 894, 740	0	5, 894, 740	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	44.000.005	ı	14 000 005		44 000 005	
	05000 OPERATI NG ROOM	14, 980, 805		14, 980, 805	0	14, 980, 805	
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
53. 00	05300 ANESTHESI OLOGY	F10 20F		T10 205	0	T10 20F	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	519, 285		519, 285	0	519, 285	1
54. 01	05401   ULTRASOUND   05700   CT   SCAN	0		0	0	0	54. 01 57. 00
57. 00	05800   MRI	0		0	0	0	
58. 00 60. 00	06000 LABORATORY	395, 088		205 000	0	205 000	58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	17, 332	<b>l</b>	395, 088 17, 332		395, 088 17, 332	1
66. 00	06600 PHYSI CAL THERAPY	•		1		· ·	•
67. 00	06700 OCCUPATI ONAL THERAPY	2, 897, 361		2, 897, 361	0	2, 897, 361 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	27, 511	_	27, 511	0	27, 511	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 510, 902	l .	1, 510, 902	0	1, 510, 902	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 011, 466	l e	18, 011, 466		18, 011, 466	
	07300 DRUGS CHARGED TO PATIENTS	2, 302, 822	l .	2, 302, 822		2, 302, 822	•
73.00	OUTPATIENT SERVICE COST CENTERS	2, 302, 622		2, 302, 622	U	2, 302, 622	73.00
91. 00	09100 EMERGENCY	0		1 0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	134, 809		134, 809	J	134, 809	
72.00	OTHER REIMBURSABLE COST CENTERS	1017007		101,007		1017007	72.00
95. 00	09500 AMBULANCE SERVICES	0		0	0	0	95. 00
200.00		46, 692, 121		46, 692, 121	0	46, 692, 121	
201.00		134, 809		134, 809		134, 809	ł
202.00	Total (see instructions)	46, 557, 312	(	46, 557, 312	0	46, 557, 312	202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150168	Peri od: Worksheet C

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/31/2016 10:	
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	8, 285, 491		8, 285, 49	1		30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	86, 033, 363	114, 620, 232	200, 653, 59		0. 000000	
	05100 RECOVERY ROOM	0	0		0. 000000	0. 000000	
	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	4, 181, 252	8, 554, 788	12, 736, 04		0. 000000	
	05401 ULTRASOUND	0	0		0. 000000	0. 000000	
	05700 CT SCAN	0	0		0. 000000	0. 000000	
	05800 MRI	0	0		0. 000000	0. 000000	
	06000 LABORATORY	3, 566, 279	1, 001, 808			0. 000000	
	06500 RESPI RATORY THERAPY	282, 464	42, 863			0. 000000	
	06600 PHYSI CAL THERAPY	4, 480, 541	12, 712, 304	17, 192, 84		0.000000	
	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0. 000000	0.000000	
69.00	06900 ELECTROCARDI OLOGY	246, 002	673, 052	919, 05	4 0. 029934	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 119, 611	8, 887, 627	19, 007, 23	8 0. 079491	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	95, 769, 060	27, 036, 380	122, 805, 44	0. 146667	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 723, 746	11, 512, 174	28, 235, 92	0. 081556	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0. 000000	0. 000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	48, 807	274, 509	323, 31	6 0. 416957	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0		0.000000	0. 000000	95. 00
200.00	Subtotal (see instructions)	229, 736, 616	185, 315, 737	415, 052, 35	3		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	229, 736, 616	185, 315, 737	415, 052, 35	3		202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150168	Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am

				5/31/2016 10: 23 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50. 00
51.00   05100   RECOVERY ROOM	0. 000000			51. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
57.00   05700   CT SCAN	0. 000000			57. 00
58. 00   05800   MRI	0. 000000			58.00
60. 00   06000   LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTE	R	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26) 1. 00	2.00	3, 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	1 0.00	11.00	0.00	
30. 00 ADULTS & PEDIATRICS	1, 207, 736	(	1, 207, 73	6, 078	198. 71	30.00
200.00 Total (lines 30-199)	1, 207, 736		1, 207, 73	6, 078		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	1, 798 1, 798		•			30. 00 200. 00

Health Financial Systems LL	ITHERAN MUSCULO	SKELETAL CENTEI	₹	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 10:	parea:
		Ti tl	e XVIII	Hospi tal	PPS	25 4111
Cost Center Description	Capi tal	Total Charges			Capital Costs	
· · · · · · · · · · · · · · · · · · ·		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 223, 310	200, 653, 595		.,		
51.00   05100   RECOVERY ROOM	0	C	0. 00000		0	
53. 00 05300 ANESTHESI OLOGY	0	C	0. 00000		0	00.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 096	12, 736, 040	•			
54. 01   05401   ULTRASOUND	0	C	0.00000		0	
57.00   05700   CT   SCAN	0	C	0.00000		0	
58. 00   05800   MRI	0	C	0.00000		0	
60. 00   06000   LABORATORY	657					
65. 00 06500 RESPI RATORY THERAPY	32					
66. 00 06600 PHYSI CAL THERAPY	4, 250	17, 192, 845				
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C	0.00000		0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	66					69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496, 009		•			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 960					
73. 00 O7300 DRUGS CHARGED TO PATIENTS	3, 881	28, 235, 920	0. 00013	4, 770, 080	654	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	0	C	0.00000		0	,
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	27, 620	323, 316	0. 08542	27 16, 397	1, 401	92. 00
OTHER REIMBURSABLE COST CENTERS		1				
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50-199)	1, 783, 881	406, 766, 862	2	64, 342, 103	231, 814	200. 00

Health Financial Systems	UTHERAN MUSCULOS	SKELETAL CENTE	2	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	ΓS Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	)	0 0	0	30.00
200.00 Total (lines 30-199)	0	C		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8.00	9. 00	1	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 078	0. 00	1, 79	8 0		30. 00
200.00   Total (lines 30-199)	6, 078		1, 79	8 0	)	200. 00

Heal th	Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	?	In Lie	u of Form CMS-:	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS			CCN: 150168	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	)	0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	)	0	0	54. 00
54. 01	05401 ULTRASOUND	0	0	)	0	0	54. 01
57.00	05700  CT SCAN	0	0	1	0	0	57. 00
58. 00	05800  MRI	0	0	1	0	0	58. 00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0		0	0	,
00 00	00000 ODCEDVATION DEDC (NON DICTINCT DADT						1 00 00

0

0 0

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0 92.00 95.00 0 200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PAS	S Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/31/2016 10:	pared: 23 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7. 00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
0.00   05000   OPERATING ROOM	0	200, 653, 595	0.00000	0. 000000	24, 638, 204	50.00
1.00   05100   RECOVERY ROOM	0	0	0.00000	0.000000	0	51.00
3. 00   05300   ANESTHESI OLOGY	0	0	0. 00000	0.000000	0	53.00
4. 00   05400   RADI OLOGY-DI AGNOSTI C	0	12, 736, 040	0.00000	0. 000000	1, 268, 287	54.00
4. 01   05401   ULTRASOUND	0	0	0.00000	0. 000000	0	54. 01
7. 00  05700 CT SCAN	0	0	0. 00000	0. 000000	0	57.00
8. 00  05800 MRI	0	0	0. 00000	0.000000	0	58.00
0. 00   06000   LABORATORY	0	4, 568, 087	0.00000	0.000000	1, 109, 387	60.00
5. 00 06500 RESPI RATORY THERAPY	0	325, 327	0. 00000	0.000000	130, 037	65.00
6. 00 06600 PHYSI CAL THERAPY	0	17, 192, 845	0. 00000	0. 000000	1, 327, 898	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	0. 000000	0	
8. 00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	
9. 00 06900 ELECTROCARDI OLOGY	0	919, 054			86, 418	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 007, 238			2, 786, 543	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS					28, 208, 852	
3. 00 07300 DRUGS CHARGED TO PATIENTS					4, 770, 080	
OUTPATIENT SERVICE COST CENTERS		20/200/720	0.0000	0.00000	1,770,000	1 / 0. 00
1. 00 09100 EMERGENCY	0	0	0.00000	0. 000000	0	91.00
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		l .				
OTHER REIMBURSABLE COST CENTERS		020,010	3.00000	3. 000000	10, 077	1 /2.00
5. 00 09500 AMBULANCE SERVICES						95. 00
00.00 Total (lines 50-199)	0	406, 766, 862			64, 342, 103	

Health Financial Systems	LUTHERAN MUSCULOSKELE	ETAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150168	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

							5/31/2016 10:	:23 am_
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Out	oati ent	Outpati ent			
		Program	Pr	ogram	Program			
		Pass-Through	Ch	arges	Pass-Through			
		Costs (col. 8			Costs (col. 9	1		
		x col. 10)			x col. 12)			
		11.00	1	2.00	13. 00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14	4, 415, 692	(	O		50. 00
	05100 RECOVERY ROOM	0		0	(	O		51. 00
53. 00	05300 ANESTHESI OLOGY	0		0	(	O		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	•	1, 081, 150	(	O		54. 00
54. 01	05401 ULTRASOUND	0		0	(	O		54. 01
57.00	05700 CT SCAN	0		0	(	O		57. 00
58. 00	05800  MRI	0		0	(	O		58. 00
60.00	06000 LABORATORY	0		103, 544	(	O		60.00
65.00	06500 RESPI RATORY THERAPY	0		9, 500	(	)		65. 00
66.00	06600 PHYSI CAL THERAPY	0		9, 112	(	)		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	(	)		67. 00
68.00	06800 SPEECH PATHOLOGY	0		0	(	)		68. 00
69.00	06900 ELECTROCARDI OLOGY	0		188, 702	(	)		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1, 105, 373	(	O		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	- :	2, 853, 599	(	O		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1, 249, 014	(	O		73. 00
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0		0	(	)		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		36, 977	(	O		92. 00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	o	2	1, 052, 663	(	o		200. 00

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CENTER		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150168	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	1	Period: From 01/01/2015 Fo 12/31/2015	Worksheet D Part V Date/Time Pre 5/31/2016 10:	
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				_		
50. 00   05000   OPERATI NG ROOM	0. 074660			0	1, 076, 276	
51.00   05100   RECOVERY ROOM	0. 000000		(	0	0	51. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	l .	(	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 040773	1, 081, 150	(	0	44, 082	54.00
54. 01  05401 ULTRASOUND	0. 000000	0	(	0	0	54. 01
57.00   05700   CT   SCAN	0. 000000	0		0	0	57.00
58. 00   05800 MRI	0. 000000	0	(	0	0	58. 00
60. 00   06000   LABORATORY	0. 086489	103, 544		0	8, 955	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 053276			0	506	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 168521	9, 112		0	1, 536	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 029934	188, 702		0	5, 649	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 079491	1, 105, 373		0	87, 867	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 146667	2, 853, 599		0	418, 529	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 081556			5 0	101, 865	73. 00
OUTPATIENT SERVICE COST CENTERS				<u>.                                      </u>		
91. 00 09100 EMERGENCY	0. 000000	0	(	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416957	36, 977		0	15, 418	92.00
OTHER REIMBURSABLE COST CENTERS				<u>.                                      </u>		
95. 00 09500 AMBULANCE SERVI CES	0. 000000		(	)		95. 00
200.00 Subtotal (see instructions)		21, 052, 663	27, 70!	5 0	1, 760, 683	200. 00
201.00 Less PBP Clinic Lab. Services-Program				o o		201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		21, 052, 663	27, 70!	5 0	1, 760, 683	202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELE	ETAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150168		Worksheet D
			From 01/01/2015	

					To 12/31/2015	Date/Time Pro 5/31/2016 10:	
			Ti t	le XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	4			
	ANCILLARY SERVICE COST CENTERS	6.00	7. 00				
	05000 OPERATING ROOM			ol			50.00
	05100 RECOVERY ROOM	0					51.00
	05300 ANESTHESI OLOGY	0					53.00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
	05400 RADI OLOGI - DI AGNOSTI C	0					54. 00
	05700 CT SCAN						57. 00
	05800 MRI						58.00
	06000 LABORATORY						60.00
	06500 RESPI RATORY THERAPY						65. 00
	06600 PHYSI CAL THERAPY	0		n l			66.00
	06700 OCCUPATI ONAL THERAPY	0					67. 00
	06800 SPEECH PATHOLOGY	0					68. 00
	06900 ELECTROCARDI OLOGY	0					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		ol			72.00
	07300 DRUGS CHARGED TO PATIENTS	2, 260		ol			73. 00
	OUTPATIENT SERVICE COST CENTERS		l	-			
91.00	09100 EMERGENCY	0		0			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		ol			92.00
	OTHER REIMBURSABLE COST CENTERS	·		•			
95.00	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)	2, 260		ol			200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	2, 260		0			202. 00

Health Financial Systems	THERAN MUSCULO	SKELETAL CENTI	ER	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2015 To 12/31/2015		
		Ti	tle XIX	Hospi tal	Cost	
Cost Center Description	Nursing School	Allied Healtl	n All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	0		0	0 0	0	30.00
200.00 Total (lines 30-199)	0		o	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col	. Inpatient	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	•			·		
30. 00 03000 ADULTS & PEDI ATRI CS	6, 078	O. C	0 38	34 0		30. 00
200.00 Total (lines 30-199)	6, 078		38	34 0		200.00

111-4-	Financial Customs	ITHEDAN MUCCHI O	CVELETAL CENTER		1 1 :-	£ F ONC	2552 40
		THERAN MUSCULOS				eu of Form CMS-2	<u> 2552-10</u>
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period: From 01/01/2015	Worksheet D Part IV	
THROUG	H COSTS				To 12/31/2015		nared.
					12/01/2010	5/31/2016 10:	23 am
				le XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Health	n All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54. 00
54. 01	05401 ULTRASOUND	0	0		0	0	54. 01
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	•		•	<u> </u>		1
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
02.00	00200 OBSEDVATION DEDS (NON DISTINCT DART	1	l	[		1 ^	02.00

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0 92.00 95.00 0 200. 00

Health Financial Systems LU APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	THERAN MUSCULOS			In Lie Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	VICE UTILK PAS	3 Frovider		From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre 5/31/2016 10:	
			le XIX	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	•	,				
50. 00   05000   OPERATING ROOM	0	200, 653, 595	1		1, 049, 770	1
51. 00   05100   RECOVERY ROOM	0	0	0.00000		0	
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	12, 736, 040			57, 274	
54. 01   05401   ULTRASOUND	0	0	0.00000		0	54. 01
57. 00  05700 CT SCAN	0	0	0.00000		0	
58. 00  05800   MRI	0	0	0.00000		0	
60. 00   06000   LABORATORY	0	4, 568, 087			53, 389	
65. 00 06500 RESPIRATORY THERAPY	0	325, 327	0.00000	0. 000000	274	65.00
66. 00   06600 PHYSI CAL THERAPY	0	17, 192, 845	0.00000	0. 000000	49, 098	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0. 000000	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0.00000	0. 000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	919, 054	0.00000	0.00000	4, 837	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 007, 238	0.00000	0. 000000	124, 095	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	122, 805, 440	0. 00000	0. 000000	1, 014, 823	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	28, 235, 920	0.00000	0. 000000	211, 641	73.00
OUTPATIENT SERVICE COST CENTERS						1
91. 00 09100 EMERGENCY	0	0	0.00000	0. 000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	323, 316	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS			•			1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	406, 766, 862			2, 565, 201	lann nn

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER In Lieu			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150168	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/31/2016 10:23 am

Title XIX							5/31/2016 10:	23 am
Program   Program   Program   Program   Program   Program   Pass-Through   Costs (col. 8 x col. 10)   x col. 12)   x col				Ti t	le XIX	Hospi tal	Cost	
Pass-Through Costs (col. 8 x col. 10)	Cost Center Descrip	ti on	Inpatient 0	utpati ent	Outpati ent			
Costs (col. 8				Program				
X COL. 10)   X COL. 12)				Charges				
11.00   12.00   13.00								
ANCI LLARY SERVI CE COST CENTERS								
50.00   05000   0PERATING ROOM   0   0   0   0   0   0   0   0   0			11. 00	12. 00	13. 00			
S1.00		NTERS						
53.00   05300   ANESTHESI OLOGY   0   0   0   0   53.00     54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0     54.01   05401   ULTRASOUND   0   0   0   0     57.00   05700   CT SCAN   0   0   0   0     58.00   05800   MRI   0   0   0   0     58.00   05800   MRI   0   0   0   0     60.00   06000   LABORATORY   0   0   0   0     65.00   06500   RESPI RATORY THERAPY   0   0   0   0     66.00   06600   PHYSI CAL THERAPY   0   0   0   0     67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0     68.00   06800   SPEECH PATHOLOGY   0   0   0     68.00   06900   ELECTROCARDI OLOGY   0   0   0     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0     72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0     73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0     91.00   09100   EMERGENCY   0   0   0     92.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0     95.00   OTHER REI MBURSSABLE COST CENTERS   95.00			0	0	(			
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0       0       0       54. 00         54. 01       05401 ULTRASOUND       0       0       0       54. 01         57. 00       05700 CT SCAN       0       0       0       0       57. 00         58. 00       05800 MRI       0       0       0       0       58. 00         60. 00       06000 LABORATORY       0       0       0       0       60. 00         65. 00       06500 RESPI RATORY THERAPY       0       0       0       65. 00         66. 00       06600 PHYSI CAL THERAPY       0       0       0       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0       0       0       66. 00         68. 00       06800 SPEECH PATHOLOGY       0       0       0       67. 00         68. 00       06900 ELECTROCARDI OLOGY       0       0       0       69. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       0       0       73. 00         91. 00       09200 OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0	1 1		0	0	(			1
54. 01       05401       ULTRASOUND       0       0       0       54. 01         57. 00       05700       CT SCAN       0       0       0       0       57. 00         58. 00       05800       MRI       0       0       0       0       58. 00         60. 00       06000       LABORATORY       0       0       0       0       60. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       0       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       0       65. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0       0       0       0       67. 00         68. 00       06800       SPECH PATHOLOGY       0       0       0       67. 00         68. 00       06900       ELECTROCARDI OLOGY       0       0       0       68. 00         69. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       73. 00         00TPATI ENT SERVI CE COST CENTERS       0       <			0	0	(			1
57. 00       05700       CT SCAN       0       0       0       57. 00         58. 00       05800       MRI       0       0       0       0       58. 00         60. 00       06000       LABORATORY       0       0       0       0       60. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       0       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       0       66. 00         67. 00       06700       OCCUPATI ONAL THERAPY       0       0       0       0       67. 00         68. 00       06800       SPEECH PATHOLOGY       0       0       0       68. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       68. 00         69. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       67. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       73. 00         00 10 200       08500       08500		C	0	0	(			
58. 00 05800 MRI 00 06000 LABORATORY 00 00 00 00 065. 00 06500 RESPI RATORY THERAPY 00 00 00 066. 00 06600 PHYSI CAL THERAPY 00 00 067. 00 06700 OCCUPATI ONLA THERAPY 00 00 068. 00 06800 SPEECH PATHOLOGY 00 069. 00 06900 ELECTROCARDI OLOGY 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 00 072. 00 07300 DRUGS CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 07300 DRUGS CHARGED TO PATI ENTS 00 07400 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 00 07500 DRUGS CHARGED TO PATI ENTS 00 07700 OP100 EMERGENCY 00 09100 EMERGENCY 00 09100 BEBRGENCY 00 09100 BEBRGENCY 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 00 07500 AMBULANCE SERVI CES	54. 01  05401 ULTRASOUND		0	0	(			54. 01
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0	57.00  05700   CT   SCAN		0	0	(			
65. 00	58. 00  05800 MRI		0	0	(			58. 00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   73. 00   0017PATI ENT SERVI CE COST CENTERS    91. 00   09100   EMERGENCY   0   0   0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   0   0   0   0   0   0	60. 00  06000   LABORATORY		0	0	(			60.00
67. 00	65. 00 06500 RESPI RATORY THERAPY	•	0	0	(			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY		0	0	(			66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAP	Υ	0	0	(			67. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   71. 00   72. 00   72. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0	68.00 06800 SPEECH PATHOLOGY		0	0	(			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 0 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	69. 00 06900 ELECTROCARDI OLOGY		0	0	(			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 0 0 73. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CH	ARGED TO PATIENT	0	0	(			71. 00
OUTPATIENT SERVICE COST CENTERS   91.00   09100   EMERGENCY   0   0   0   0   91.00	72.00 07200 I MPL. DEV. CHARGED	TO PATIENTS	O	0	(			72. 00
91. 00	73.00 07300 DRUGS CHARGED TO PA	TI ENTS	o	0	(			73. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   0	OUTPATIENT SERVICE COST O	CENTERS						
OTHER REI MBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVI CES   95. 00	91. 00 09100 EMERGENCY		0	0	(	)		91. 00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (N	ON-DISTINCT PART	o	0	(			92. 00
	OTHER REIMBURSABLE COST O	ENTERS	<u> </u>			•		1
200. 00   Total (lines 50-199)   0   0   0   200. 00	95. 00 09500 AMBULANCE SERVICES							95. 00
	200.00 Total (lines 50-199	)	o	0	(			200.00

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150168	Peri od:	Worksheet D

From 01/01/2015 | Part V | Date/Time Prepared: 5/31/2016 10:23 am Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1.00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.074660 1, 133, 018 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05300 ANESTHESI OLOGY 0.000000 0 0 53 00 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0.040773 77, 575 0 54.00 54.01 05401 ULTRASOUND 0.000000 0 54.01 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 0 05800 MRI 0 0 58.00 0.000000 0 0 58.00 60.00 06000 LABORATORY 0.086489 11, 626 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 0.053276 1,004 0 65.00 0 06600 PHYSI CAL THERAPY 97, 551 66 00 0.168521 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.029934 0 0 4, 470 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.079491 0 60, 630 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.146667 0 0 242, 648 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 081556 284, 761 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 0.000000 0 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 416957 0 8, 243 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 000000 0 95.00 200.00 0 200. 00 Subtotal (see instructions) C 1, 921, 526 0 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges 0 202.00

0

1, 921, 526

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CENTER		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150168	Peri od:	Worksheet D

From 01/01/2015 Part V
To 12/31/2015 Date/Time Prepared: 5/31/2016 10:23 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 84, 591 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 0 51.00 53. 00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 3, 163 54.00 54.01 05401 ULTRASOUND 54.01 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 0 58.00 60.00 06000 LABORATORY 1,006 60.00 06500 RESPIRATORY THERAPY 53 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 16, 439 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69.00 134 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 4.820 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 35, 588 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 23, 224 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 3, 437 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 172, 455 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00 Only Charges o 202. 00 202.00 Net Charges (line 200 +/- line 201) 172, 455

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Pr		Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prep 5/31/2016 10:2		
		Title XVIII	Hospi tal	PPS		
0 1 0 1 1 11						

			12, 01, 2010	5/31/2016 10:	23 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DART I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	evaludina newborn)		6, 078	1. 00
2.00	Inpatient days (including private room days and swing-bed days,			6, 078	2. 00
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days	0,078	3. 00
3.00	do not complete this line.	7. IT you have only pr	i vate i oom days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		5, 939	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0,707	5. 00
0.00	reporting period	dayo, oag zooozo	. 0. 0	ا	0.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 /			
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 798	9. 00
10.00	newborn days)	. (:!			10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		doni days) arter	J	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	sing (the daing privat	c room days)	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room davs)	o	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program			0	14.00
15.00	Total nursery days (title V or XIX only)		-	0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period			'	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
10.00	reporting period		464	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through becember 31 or	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ha cost	0.00	20. 00
20.00	reporting period	arter becember 51 or t	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			5, 894, 740	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ina period (line	0	22. 00
	5 x line 17)		3   1		
23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_ '	
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
27 00	x line 20)				27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus Lino 24)		0 5, 894, 740	26. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 lill flus 11 fle 26)		3, 694, 740	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation had ch	arnos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed cir	ai ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line		,	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	5, 894, 740	
	27 minus line 36)		·		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	,		969. 85	
39. 00	Program general inpatient routine service cost (line 9 x line 3	,		1, 743, 790	
40.00	Medically necessary private room cost applicable to the Program	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 +	iine 40)		1, 743, 790	41.00

Heal th	Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTE	R	In lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST			CCN: 150168	Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			T: ±1	- WHII		5/31/2016 10:	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	oost contor bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			6, 975, 123	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructio	ons)		8, 718, 913	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvices (from	m Wkst D sum	m of Parts L and	357, 281	50. 00
30.00		attent routine	services (IIO	ii wkst. D, Suii	ii Oi Faits i ailu	337, 201	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fi	om Wkst. D, s	sum of Parts II	231, 814	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				589, 095	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anesth	netist, and	8, 129, 818	•
	medical education costs (line 49 minus line	52)		•			
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00							55. 00
56.00	Target amount (line 54 x line 55)					0	
57. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996. u	updated and co	ompounded by the	0.00	58. 00 59. 00
07.00	market basket		9	•	simpounded by the		
60.00					46 b	0.00	•
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		is (iiiies oi x	00), 01 1% 01	the target		
62.00		+ / :+				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	actions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	oer 31 of the (	cost reporting	neriod (See	0	65. 00
03.00	instructions) (title XVIII only)	ts arter becein	ber 31 of the t	cost reporting	g perrou (see		03.00
66. 00	1	ne costs (line	64 plus line 6	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 d	of the cost re	eportina period	0	67. 00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [	December 31 of	the cost repo	orting period	0	68. 00
69. 00		routine costs (	(line 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-			)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		•			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74. 00 75. 00
70.00	26, line 45)	routine service		nor Roncet B, 1	are rr, corumn		70.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		provi der record	ds)			79.00
80.00	Total Program routine service costs for comp	arison to the c		*.	nus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
82.00	Reasonable inpatient routine service cost it ill tation (i		* .				82.00
84. 00	1		•				84. 00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougn 85)				86. 00
87. 00						139	87. 00
88. 00						969. 85	
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)	,			134, 809	89. UU

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 10:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	1, 207, 736	5, 894, 740	0. 20488	4 134, 809	27, 620	90.00
91.00 Nursing School cost	0	5, 894, 740	0.00000	134, 809	0	91.00
92.00 Allied health cost	0	5, 894, 740	0.00000	134, 809	0	92.00
93.00 All other Medical Education	0	5, 894, 740	0. 00000	134, 809	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150168	Peri od: From 01/01/2015	Worksheet D-1	
		To 12/31/2015	Date/Time Pre 5/31/2016 10:	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

Digit   ALL PROVIDER COMPONENTS   1.00			Title XIX	Hospi tal	5/31/2016 10:: Cost	23 am_
IPART L - ALL PROVIDER COMPONENTS   IMPATENT MAY		Cost Center Description				
Inpatient days (Including private room days, and seing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS			1.00	
Injection tasks (Including private room days, excluding safing-bed and newborn days)   6,078   2,00	1 00				/ 070	1 00
Private room days (excluding swing-bed and observation bed days)   1						
Semi-private room days (excluding sating-hed and observation bed days)  5, 939 4 .00  6. 00 Total saing-hed SMF type inpatient days (including private room days) after December 31 of the cost of the			<i>y</i> ,	ivate room days,		
10.00   Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost of reporting period   Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost or reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed SWF syle inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days)   Total swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days)   Total swing-bed SWF type inpatient days applicable to the swing swing private room days)   Total swing-bed SWF type inpatient days applicable to the swing swing swing private room days)   Total swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days)   Total swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days)   Total swing-bed SWF type inpatient days applicable to the swing swing-bed days)   Total swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed days)   Total swing-bed SWF swing-be				-	5 000	
reporting period (if call endar year, enter 0 on this line)  7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line)  9.00 Swing-bed SNF type inpatient days applicable to this line)  9.00 Swing-bed SNF type inpatient days applicable to this line)  9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (see instructions)  13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after 0 through December 31 of the cost reporting period (see instructions)  13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after 0 through December 31 of the cost reporting period (see instructions)  13.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost of the cost reporting period (see instructions)  13.00 Swing-bed Cost applicable to SNF type services applicable to services after December 31 of the cost of the cost reporting period (see instructions)  13.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x XIIne 17)  13.00 Swing-bed cost applicable to SNF type services after De				r 31 of the cost		
reporting period (if Callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if Callendar year, enter 0 on this line) 9.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Callendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0 10.00 through December 31 of the cost reporting period (if Callendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 December 31 of the cost reporting period (if Callendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type services applicable to services through December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services through December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services after December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services after December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services after December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services after December 31 of the cost 10.00 Including 15.00 SNF type services applicable to services after December	3.00		days) through becembe	1 31 01 1110 0031	O	3.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost on the sun of the swing-bed NF type inpatient days including private room days applicable to the Program (excluding swing-bed and seven cost inpatient days including private room days applicable to the Program (excluding swing-bed and seven cost inpatient days including private room days applicable to the Program (excluding swing-bed and seven cost days) after becember 31 of the cost reporting period (see instructions)   10.00 king-bed SNF type inpatient days applicable to the transition of this line)   10.00 king-bed SNF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if cal endar year, enter 0 on this line)   12.00 king-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   12.00 king-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00 ked call y necessary private room days applicable to the Program (excluding swing-bed days)   13.00 ked call y necessary private room days applicable to the Program (excluding swing-bed days)   14.00 ked call y necessary private room days applicable to services through December 31 of the cost reporting period   15.00 ked care rate for swing-bed SNF services applicable to services after December 31 of the cost   15.00 ked care rate for swing-bed NF services applicable to services after December 31 of the cost   15.00 ked care rate for swing-bed NF services applicable to services after December 31 of the cost   15.00 ked care rate for swing-bed NF services applicable to services after December 31 of the cost   15.00 ked call drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   15.00 ked call drate for swing-bed NF services after December 31 of the cost reporting peri	6.00		days) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorn days)  10. 03 sing-bed. Swing-bed swin	7 00		davs) through December	31 of the cost	0	7 00
reporting period (if calendar year, enter 0 on this Iline)  10.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days)  12.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days) after strong becember 31 of the cost reporting period (see Instructions)  12.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days) after strong becember 31 of the cost reporting period (see Instructions)  13.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see Instructions)  13.00 Sking-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days) of the cost reporting period (including private room days applicable to services after December 31 of the cost reporting period (line on the private room days) of the cost applicable to SNF type services through December 31 of the cost reporting period (line on the private room charges (excluding swing-bed cost (sine tinstructions) on the cost applicable to NF type	7.00	] 31 1 3 1 91	aayo, em oagn boombor	0. 0. 1 0001	· ·	7.00
10.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   0.00   10.00	8.00		days) after December 3	1 of the cost	0	8. 00
newborn days)  newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  12.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.01 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days)  17.00 Nursery days (title V or XIX only)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including Swing-bed Swing-be	9. 00		the Program (excluding	swing-bed and	384	9. 00
through December 31 of the cost reporting period (see instructions)  1.0 Sing-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)  1.2 Os inja-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.0 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.0 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.0 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost reporting period (if calendar year, enter 0 on this Iine)  1.0 Os in the cost of the cost reporting period (if calendar year, enter 0 on the cost reporting period (if calendar year, enter 0		newborn days)	0 1			
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12.00 Swing-bed NF type inpatient days applicable to titles \( \tilde{\tilde{V}} \) or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 v line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 18)  26.00 General inpatient routine service cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 min	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period  10. 00 Ming-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  11. 00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  12. 00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  13. 00 No Norsery days (title V or XIX only)  14. 00 Modically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Norsery days (title V or XIX only)  16. 00 Norsery days (title V or XIX only)  17. 00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 2 2 00 2 00 1 00 1 00 1 00 1 00 1 00	40.00					40.00
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reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)  27. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29. 00 Swing-bed cost (see instructions)  29. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  29. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  29. 00 Swing-bed cost (see charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room per diem charge (line 29 * line 3)  30. 00 Semi-private room conditions swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 * line 28)  32. 00 Average peridem private room cost differential (line 3 x line 31)  33. 00 Average peridem private room cost differential (line 3 x line 31)  34. 00 Average peridem private room cost differential (line 3 x line 35)  35. 00 Average peridem private room cost differential (line 3 x line 35)  36.	17 00		through Docombon 21 o	f the cost	0.00	17.00
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	Financial Systems L TATION OF INPATIENT OPERATING COST	UTHERAN MUSCULO		R CCN: 150168	In Lie	wof Form CMS-2 Worksheet D-1	
COMITO	ATTON OF THIRATENT OF ENATTING COST		Trovider	CCN. 130100	From 01/01/2015 To 12/31/2015		
				VIV		5/31/2016 10:	23 am
	Cost Center Description	Total	Total	tle XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost		sDiem (col. 1	3	(col. 3 x col.	
		1.00	2.00	3. 00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units	6					
43. 00 44. 00							43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	3, line 200)			269, 729	48. 00
	Total Program inpatient costs (sum of lines			ons)		642, 151	1
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51.00
	and IV)	•	•	•			
52.00	Total Program excludable cost (sum of lines		طع مم ما	uoi oi on onco+l	notiot and	0	
53. 00	Total Program inpatient operating cost excluded in medical education costs (line 49 minus line		nateu, non-ph	ysıcıan anesti	ietist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges					0	
56. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	,	ting cost and ta	arget amount (	line 56 minus	line 53)		
58. 00							58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	ndated by the	market hasket		0.00	60.00
61. 00					the amount by	0.00	
	which operating costs (line 53) are less th		ts (lines 54 x	60), or 1% or	f the target ´		
62 00	amount (line 56), otherwise enter zero (see	instructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	(11111111111111111111111111111111111111					
64. 00	3 1	sts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the	cost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)						00.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31	of the cost re	enorting period	0	67.00
07.00	(line 12 x line 19)	ne costs till odgi	i becember 31	or the cost is	sporting period	Ĭ	07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after [	December 31 of	the cost repo	orting period	0	68. 00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs /	lino 67 . lin	o 69)		0	69.00
09.00	PART III - SKILLED NURSING FACILITY, OTHER I					0	1 09.00
70. 00	Skilled nursing facility/other nursing faci		•		)		70.00
71.00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost appli		n (line 14 v l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine ser						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, I	Part II, column		75. 00
74 00	26, line 45)	ino 2)					76.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 min						78.00
79. 00	Aggregate charges to beneficiaries for exce				1. 70)		79.00
80.00	Total Program routine service costs for com Inpatient routine service cost per diem lim		cost iimitatio	n (line /8 mil	ius iine /9)		80.00
82. 00	Inpatient routine service cost per drem in Inpatient routine service cost limitation (		1)				82. 00
83. 00	Reasonable inpatient routine service costs	(see instruction	· * .				83.00
84. 00	Program inpatient ancillary services (see in		, ma)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (su						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PAS		Jugii 00)				1 30.00
87. 00	Total observation bed days (see instruction	s)				139	
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (so	•				969. 85 134, 809	
00 00							

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	1 COST					
90.00 Capital -related cost	1, 207, 736	5, 894, 740	0. 20488	4 134, 809	27, 620	90.00
91.00 Nursing School cost	0	5, 894, 740	0.00000	134, 809	0	91.00
92.00 Allied health cost	0	5, 894, 740	0.00000	134, 809	0	92.00
93.00 All other Medical Education	0	5, 894, 740	0.00000	134, 809	0	93.00

INPATIENT AN	CILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150168	Peri od:	Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	
					5/31/2016 10:	23 am
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3.00	_
I NPATI	ENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDI ATRI CS			2, 506, 684		30.0
	ARY SERVICE COST CENTERS					1
50. 00 05000	OPERATI NG ROOM		0. 07466	50 24, 638, 204	1, 839, 488	50.0
51. 00   05100	RECOVERY ROOM		0.00000	00 0	0	51.0
53. 00   05300	ANESTHESI OLOGY		0.00000	00 0	0	53.0
4.00  05400	RADI OLOGY-DI AGNOSTI C		0. 0407	73 1, 268, 287	51, 712	54.0
54. 01   05401	ULTRASOUND		0.00000	00	0	54.0
57. 00   05700	CT SCAN		0.00000	00	0	57.0
8. 00   05800	MRI		0.00000	00	0	58.0
50.00 06000	LABORATORY		0. 08648	39 1, 109, 387	95, 950	60.0
	RESPI RATORY THERAPY		0. 0532			
	PHYSI CAL THERAPY		0. 16852	, . ,	223, 779	
	OCCUPATI ONAL THERAPY		0.00000		0	1
	SPEECH PATHOLOGY		0.00000		0	1 00.0
	ELECTROCARDI OLOGY		0. 02993			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 07949			
	IMPL. DEV. CHARGED TO PATIENTS		0. 14666			
	DRUGS CHARGED TO PATIENTS		0. 0815	4, 770, 080	389, 029	73. C
	TIENT SERVICE COST CENTERS				_	4
	EMERGENCY		0.00000		_	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 4169	57 16, 397	6, 837	92.0
	REI MBURSABLE COST CENTERS					4
	AMBULANCE SERVICES			(4 242 402	/ 075 400	95. 0
	Total (sum of lines 50-94 and 96-98)	(1: (1)		64, 342, 103		
	Less PBP Clinic Laboratory Services-Program only charges	(Tine 61)	[	64 242 102		201. 0
202. 00	Net Charges (line 200 minus line 201)		I	64, 342, 103	1	202.

	Financial Systems LUTHERAN MUSCULOSKI ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150168	Peri od:	eu of Form CMS-: Worksheet D-3	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 10:	
		Ti +	le XIX	Hospi tal	Cost	23 alli
	Cost Center Description	11 (	Ratio of Cos		Inpati ent	
	oost center bescription		To Charges	Program	Program Costs	
			l onar goo	Charges	(col. 1 x col.	
				3	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			125, 647		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 0746		78, 376	
51.00	05100 RECOVERY ROOM		0.0000		0	011 00
53.00	05300 ANESTHESI OLOGY		0.0000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0407		2, 335	
54. 01	05401 ULTRASOUND		0.0000		0	1
57.00	05700 CT SCAN		0.0000		0	
58. 00	05800 MRI		0.0000		0	
60.00	06000 LABORATORY		0. 0864			
65. 00	06500 RESPI RATORY THERAPY		0. 0532			
66. 00	06600 PHYSI CAL THERAPY		0. 1685		8, 274	
67. 00	06700 OCCUPATI ONAL THERAPY		0.0000		0	
68. 00	06800 SPEECH PATHOLOGY		0.0000		0	1 00.00
69. 00	06900 ELECTROCARDI OLOGY		0. 0299		145	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0794			1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1466			
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 0815	56 211, 641	17, 261	73. 00
	OUTPATIENT SERVICE COST CENTERS				_	4
	09100 EMERGENCY		0.0000		1	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4169	57 0	0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS					1 05 65
	09500 AMBULANCE SERVI CES			0.5/5.001	0.0 700	95. 00
200.00		(1)		2, 565, 201	269, 729	
201.00		s (IIne 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)		1	2, 565, 201		202. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150168	Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1. 00	2. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurring to October 1 (see instructions)	g prior		6, 837, 221		1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring	g on or		2, 426, 977		1. 02
1. 03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1. 04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
2. 00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			4, 844		2. 00
2.01	Outlier reconciliation amount			0		2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments	ns)		0		2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost report	i ng		38. 62		4. 00
	period (see instructions) Indirect Medical Education Adjustment					
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instru			0.00		5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the	e		0.00		6. 00
	criteria for an add-on to the cap for new programs in accordance CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified uncCFR $\S412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified up LCFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		7. 01
	then see instructions.					
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8. 00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot:	s under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 20 instructions.	011, see				
8. 02	The amount of increase if the hospital was awarded FTE cap slots			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru- Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the curren			0.00		10.00
	from your records	t year				
11. 00 12. 00				0. 00 0. 00		11. 00 12. 00
13.00	Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		0.00		14. 00
15.00	Sum of lines 12 through 14 divided by 3.			0.00		15.00
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital closu	re		0. 00 0. 00		16. 00 17. 00
18. 00	Adjusted rolling average FTE count			0.00		18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20.00
22. 00				0.00000		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	•	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		he MMA	0.00		23. 00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	с Сар				
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lo	wer of		0. 00 0. 00		24. 00 25. 00
	line 23 or line 24 (see instructions)					
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)			0.00000		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ent days		2. 43		30. 00
31. 00	(see instructions) Percentage of Medicaid patient days (see instructions)			0.00		31.00
32. 00	Sum of lines 30 and 31			2. 43		32. 00
	Allowable disproportionate share percentage (see instructions)			0.00		33. 00
34.00	Disproportionate share adjustment (see instructions)			0		34. 00

From 01/01/2015 Part A Date/Time Prepared: 12/31/2015 5/31/2016 10:23 am Title XVIII Hospi tal Prior to On/After October 1 October 1 n 2 00 1 00 Uncompensated Care Adjustment 6, 406, 145, 534 35.00 7, 647, 644, 885 35.00 Total uncompensated care amount (see instructions) 35. 01 Factor 3 (see instructions) 0.000004851 0.000005795 35.01 Hospital uncompensated care payment (If line 34 is zero, 35.02 0 35.02 enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment 35.03 amount (see instructions) 36.00 Total uncompensated care (sum of columns 1 and 2 on line 36.00 35 ()3) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) Total Medicare discharges on Worksheet S-3, Part I Э 40.00 excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) 41.00 Total ESRD Medicare discharges excluding MS-DRGs 652, 0 41.00 682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding 41.01 0 41.01 MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not 42.00 0.00 42.00 qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652, 43.00 0 43.00 682, 683, 684 an 685. (see instructions) 44.00 Ratio of average length of stay to one week (line 43 0.000000 44 00 divided by line 41 divided by 7 days) 45.00 Average weekly cost for dialysis treatments (see 0.00 45.00 instructions) 46.00 Total additional payment (line 45 times line 44 times line 0 46, 00 41.01) 47 00 Subtotal (see instructions) 9, 269, 042 47 00 Hospital specific payments (to be completed by SCH and 48.00 48.00 MDH, small rural hospitals only. (see instructions) 49.00 Total payment for inpatient operating costs (see 49.00 9, 269, 042 instructions) Payment for inpatient program capital (from Wkst. L, Pt. I 50.00 50.00 737.086 and Pt. II, as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L, 51.00 0 Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4, 52.00 0 52.00 line 49 see instructions) Nursing and Allied Health Managed Care payment 53.00 53.00 54.00 Special add-on payments for new technologies 0 54.00 55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, 55.00 line 69) 56 00 Cost of physicians' services in a teaching hospital (see O 56 00 intructions) 57.00 Routine service other pass through costs (from Wkst. D, 0 57 00 Pt. III, column 9, lines 30 through 35) 58.00 Ancillary service other pass through costs from Wkst. D, 58.00 Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58) 59 00 10 006 128 59 00 60.00 Primary payer payments 30, 900 60.00 Total amount payable for program beneficiaries (line 59 9, 975, 228 61.00 61.00 minus line 60) 62.00 Deductibles billed to program beneficiaries 62.00 866, 660 63.00 Coinsurance billed to program beneficiaries 63.00 64.00 Allowable bad debts (see instructions) 5.596 64.00 65.00 Adjusted reimbursable bad debts (see instructions) 3, 637 65.00 Allowable bad debts for dual eligible beneficiaries (see 66.00 2.890 66.00 instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 9, 112, 205 67.00 Credits received from manufacturers for replaced devices 68.00 68.00 for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and 69.00 69.00 96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.00 70 00 RURAL DEMONSTRATION PROJECT 70.50 70.50 70.89 Pioneer ACO demonstration payment adjustment amount (see 70.89 instructions) HSP bonus payment HVBP adjustment amount (see 70.90 70.90 0 instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 0 70.91 Bundled Model 1 discount amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.93 70.93 66.788 HRR adjustment amount (see instructions) 70.94 70 94 0 70.95 Recovery of accelerated depreciation 0 70.95

Heal th	Financial Systems LUTHERAN MUSCULOS			u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150168	Peri od: From 01/01/2015	Worksheet E Part A	
			To 12/31/2015		enared.
			10 12/01/2010	5/31/2016 10:	
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy)		0 0		70. 96
	(Enter in column 0 the corresponding federal year for the				
70 07	period prior to 10/1)				70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the		0		70. 97
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70. 98
70. 99	HAC adjustment amount (see instructions)		0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus		9, 178, 993		71.00
71.00	lines 69 & 70)		7, 176, 776		71.00
71. 01	Seguestration adjustment (see instructions)		183, 580		71. 01
72.00	Interim payments		8, 991, 850		72. 00
73.00	Tentative settlement (for contractor use only)		0		73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,		3, 563		74.00
	72, and 73)				
75. 00	Protested amounts (nonallowable cost report items) in		205, 802		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1	
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
04 00	instructions)				04.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0		92. 00
93. 00	Capital outlier reconciliation adjustment amount (see		0		93. 00
93.00	instructions)		U		93.00
94.00	The rate used to calculate the time value of money (see		0.00		94.00
71.00	instructions)		0.00		71.00
95. 00	Time value of money for operating expenses (see		0		95. 00
	instructions)				
96.00	Time value of money for capital related expenses (see		0		96. 00
	instructions)				

Instructions)			L
	Prior to 10/1	On/After 10/1	
	1. 00	2.00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL	THERAN MUSCULOSKELETAL CENTER In Lie			u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN:		Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Ti me Prepared: 5/31/2016 10:23 am

		'	0 12/31/2015	5/31/2016 10:	
		Title XVIII	Hospi tal	PPS	25 4111
		i ii i	noopi tai		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2, 260	1
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		1, 760, 683	1
3. 00	PPS payments			3, 115, 374	1
4.00	Outlier payment (see instructions)			10, 948	1
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	•
6. 00 7. 00	Line 2 times line 5			0.00	
8.00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	1
10. 00	Organ acqui si ti ons	, cor. 10, 11116 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			-	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		,	,	
	Reasonabl e charges				
12.00	Ancillary service charges			27, 705	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			27, 705	14. 00
15 00	Customary charges			0	1 1 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00 16. 00
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e)	payment for services on	a chargebasis	U	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
18. 00	Total customary charges (see instructions)			27, 705	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds line	11) (see	25, 445	1
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds line	18) (see	0	20. 00
	instructions)			0.040	
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)			21.00
22. 00	Interns and residents (see instructions)	ati ana)		0	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)		3, 126, 322	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			5, 120, 322	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			18	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		611, 753	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22 a	nd 23] (see	2, 516, 811	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 516, 811	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)			2, 516, 811	ı
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)		2,010,011	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	-		0	33.00
34.00	Allowable bad debts (see instructions)			68, 335	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			44, 418	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		68, 335	1
37. 00	Subtotal (see instructions)			2, 561, 229	1
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 98	Prioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace	d davisas (saa instrusti	one)	0	
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see ilistructi	UIIS)	0	
40. 00	Subtotal (see instructions)			2, 561, 229	•
40. 01	· · · · · · · · · · · · · · · · · · ·			51, 225	1
41. 00				2, 464, 613	•
42.00				0	•
43.00				45, 391	1
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,			0	44.00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	1
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
74.00	Trotal (Sum of Files / and 70)		ļ	U	1 /4.00

Health Financial Systems LUTHERA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2015 Part I
To 12/31/2015 Date/Ti me Prepared: 5/31/2016 10: 23 am Provi der CCN: 150168

					5/31/2016 10: 2	23 am_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		8, 991, 850		2, 464, 613	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			1		
3. 01	ADJUSTMENTS TO PROVIDER		(	)	0	3. 01
3. 02	TIBS GOT MENT OF THE TREET OF T				l ő	3. 02
3. 03			(		0	3. 03
3. 04					o o	3. 04
3. 05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3.52			C	)	0	3. 52
3.53			C	)	0	3. 53
3.54			C	)	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 991, 850	)	2, 464, 613	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		1 0	5. 01
5. 02	TENTATIVE TO PROVIDER					5. 02
5. 02						5. 02
0.00	Provider to Program			<b>'</b>		0.00
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51			C		o	5. 51
5. 52			Ċ		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		3, 563	3	45, 391	6. 01
6.02	SETTLEMENT TO PROGRAM		C		0	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 995, 413		2, 510, 004	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	0.00
8.00	Name of Contractor				1	8. 00

Heal th	Financial Systems LUTHERAN MUSCULOSKEL	ETAL CENTER	In Lie	u of Form CMS-2	2552-10	
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 150168   Period: From 01/01/2015   To 12/31/2015				pared: 23 am	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	2.00   Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		5, 939	4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			415, 052, 353	5. 00	
6.00	6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 31					
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I					
8.00	OO Calculation of the HIT incentive payment (see instructions)					
9.00	Sequestration adjustment amount (see instructions)		6, 394	9. 00		
10.00	IO.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			321, 339	30.00	
31.00	Other Adjustment (specify)			0	31.00	
22 00	00 Polance due provider (line 0 (or line 10) minus line 30 and line 31) (see instructions)					

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

321, 339 30. 00 0 31. 00 -8, 049 32. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTE	R	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150168	From 01/01/2015	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2016 10:23 am

			Го 12/31/2015	Date/Time Pre 5/31/2016 10:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		642, 151		1. 00
2.00	Medical and other services			172, 455	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		642, 151	172, 455	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		642, 151	172, 455	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8.00	Routine service charges		2 5/5 201	1 001 507	8. 00
9.00	Ancillary service charges		2, 565, 201	1, 921, 526	1
10. 00 11. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10. 00 11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 565, 201	1, 921, 526	1
12.00	CUSTOMARY CHARGES		2, 303, 201	1, 721, 320	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
13.00	basis	ser vices on a charge		O	13.00
14. 00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	- ( )	0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		2, 565, 201	1, 921, 526	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 923, 050	1, 749, 071	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		642, 151	172, 455	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provide	ers.	0	22.00
22. 00	Other than outlier payments Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	U	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		642, 151	172, 455	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			•	
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		642, 151	172, 455	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		642, 151	172, 455	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		(40.454	0	37. 00
	Subtotal (line 36 ± line 37)		642, 151	172, 455	1
	Direct graduate medical education payments (from Wkst. E-4)		(42.151	170 455	39. 00
40. 00 41. 00			642, 151	172, 455	
41.00	.			0 172, 455	
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	e with CMS Dub 15-2	642, 151	172, 455	42.00
<del>-</del> 3.00	chapter 1, §115.2	5 W. CH 5W5 1 UD 15-2,		O	75.00
	1		1		'

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

Provi der CCN: 150168

| Period: | Worksheet G | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/31/2016 10: 23 am

					5/31/2016 10:	23 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	CHIPDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-4, 411, 094		N 0	0	1.00
2. 00	Temporary investments	-4, 411, 094		0	0	2.00
3. 00	Notes recei vabl e			_	0	
4. 00	Accounts receivable	19, 770, 370		o o	0	
5.00	Other recei vable	C		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-2, 231, 380	) c	0	0	6. 00
7.00	Inventory	1, 694, 845	s  c	0	0	7. 00
8.00	Prepai d expenses	221, 969	ol c	0	0	
9. 00	Other current assets	446, 584		1	0	9. 00
10. 00	Due from other funds	0	0	-	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	15, 491, 294	·  C	) 0	0	11. 00
40.00	FI XED ASSETS					40.00
12.00	Land	24 745			0	1
13. 00 14. 00	Land improvements Accumulated depreciation	26, 765 -9, 279	•	_		13. 00 14. 00
15. 00	Buildings	6, 971			0	15. 00
16. 00	Accumulated depreciation	-1, 744	1	_	0	16.00
17. 00	Leasehold improvements	771, 421		_	Ö	17. 00
18. 00	Accumulated depreciation	-138, 902		0	Ō	18. 00
19.00	Fi xed equipment	408, 145		0	0	19. 00
20.00	Accumulated depreciation	-132, 248	s c	0	0	20. 00
21.00	Automobiles and trucks	0	) c	0	0	21. 00
22. 00	Accumul ated depreciation	0	) c	0	0	22. 00
23. 00	Major movable equipment	8, 616, 207	'  C	0	0	23. 00
24. 00	Accumul ated depreciation	-5, 481, 945		1	0	24. 00
25. 00	Mi nor equi pment depreci abl e	1, 287, 711		1	0	25. 00
26. 00	Accumulated depreciation	-972, 223	S	0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation			_	0	28. 00 29. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	4, 380, 879	1	_		30.00
30.00	OTHER ASSETS	4, 300, 677	1	<u>,                                     </u>	0	30.00
31. 00	Investments		) (	0	0	31.00
32. 00	Deposits on Leases			-	Ō	32. 00
33.00	Due from owners/officers	i c		0	0	33. 00
34.00	Other assets	1, 189, 321		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1, 189, 321		0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	21, 061, 494	C	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	4, 200, 611	1	-		37. 00
38. 00	Sal ari es, wages, and fees payable	1, 174, 979	1	_	0	38. 00
39. 00	Payroll taxes payable	111, 078	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	16, 667		0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments			) O	U	41. 00 42. 00
43. 00	Due to other funds	-214, 941, 715		0	0	1
44. 00	Other current liabilities	496, 231	1	0		
45. 00	Total current liabilities (sum of lines 37 thru 44)	-208, 942, 149	1	1		
	LONG TERM LIABILITIES	200, 712, 147				1
46. 00	Mortgage payable	О	) C	0	0	46. 00
47. 00	Notes payable	33, 333	d	0		
48.00	Unsecured Loans	0	) c	0	0	48. 00
49.00	Other long term liabilities	32, 753, 516	o  c	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	32, 786, 849	ol c	0		
51.00	Total liabilites (sum of lines 45 and 50)	-176, 155, 300	) C	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	197, 216, 794				52.00
53. 00	Specific purpose fund		C	)		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance			0	0	56. 00 57. 00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		1		0	58.00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	197, 216, 794		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	21, 061, 494		o o	Ö	60.00
	59)					

Provi der CCN: 150168

Ceneral Fund   Special Purpose Fund   Endowment Fund						То	12/31/2015	Date/Time Prep 5/31/2016 10:2	
1.00			General	Fund	Speci al	Pur	pose Fund		eo aiii
1.00									
1.00			1.00	2.00	3. 00		4. 00	5. 00	
3.00	1.00	Fund balances at beginning of period		168, 616, 909					1. 00
Additions (credit adjustments) (specify)	2.00			28, 599, 885					2. 00
5.00				197, 216, 794			0		
6.00		Additions (credit adjustments) (specify)	0			0			
7.00   8.00   9.00   10.00   1			0			0			
S. 00   O   O   O   O   O   O   O   O   O			0			0			
9.00 10.00 11.00 1						0		1	
10.00   Total additions (sum of line 4-9)   10.00   11.00   11.00   Subtotal (line 3 plus line 10)   197, 216, 794   0   11.00   12.00   0   0   0   0   0   0   0   0   0						0			
11.00   Deductions (line 3 plus line 10)   Deductions (debit adjustments) (specify)   0   197, 216, 794   0   0   11.00   12.00   13.00   14.00   0   0   0   0   0   14.00   15.00   16.00   16.00   17.00   18.00   17.00   18.00   197, 216, 794   0   197, 216, 794   0   19.00		Total additions (sum of line 4-9)		0			0	Ü	
13.00				197, 216, 794			0		11. 00
14.00   15.00   16.00   0   0   0   0   0   0   17.00   18.00   17.00   18.00   17.00   19.0	12.00	Deductions (debit adjustments) (specify)	O			0		0	12.00
15.00	13.00		0			0		0	13.00
16.00   17.00   Total deductions (sum of lines 12-17)   19.00   19.00   19.7, 216, 794   19.00   19.	14.00		0			0		0	14.00
17.00   18.00   Total deductions (sum of lines 12-17)   19.00   Fund balance at end of period per balance sheet (line 11 minus line 18)   Endowment Fund   Plant Fund   Plant Fund   19.00   10.00			0			0			
18.00   Total deductions (sum of lines 12-17)   Fund balance at end of period per balance   197, 216, 794			0			0			
19.00   Fund balance at end of period per balance sheet (line 11 minus line 18)   197, 216, 794   0   19.00		T	0			0		0	
Sheet (line 11 minus line 18)				107 217 704			-		
Endowment Fund	19.00			197, 216, 794			0		19.00
1.00   Fund balances at beginning of period   0   0   0   0   2.00   3.00   Net income (loss) (from Wkst. G-3, line 29)   0   0   0   0   3.00   4.00   Additions (credit adjustments) (specify)   0   0   0   0   0   0   0   0   0		paneer (Trie Trimings Trie 10)	Endowment Fund	PI ant	Fund				
1.00   Fund balances at beginning of period   0   0   0   0   2.00   3.00   Net income (loss) (from Wkst. G-3, line 29)   0   0   0   0   3.00   4.00   Additions (credit adjustments) (specify)   0   0   0   0   0   0   0   0   0									
2.00 3.00   Net income (loss) (from Wkst. G-3, line 29) 3.00   Additions (credit adjustments) (specify)  0   Additions (credit adjustments) (specify)  10   Additions (credit adjustments) (specify)  11   Additions (additions (sum of line 4-9) (specify)  12   Additions (additions (sum of line 4-9) (specify)  13   Additions (additions (specify) (specify) (specify)  14   Additions (specify) (specify) (specify) (specify) (specify)  15   Additions (additions (specify) (specif	4 00			7. 00	8. 00				4 00
3.00   Total (sum of line 1 and line 2)   0   3.00   4.00   5.00   6.00   7.00   8.00   9.00   10.00   11.00   12.00   13.00   14.00   15.00   15.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   10.00   17.00   17.00   10.00   17.00   10.00   17.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   10.00   17.00   17.00   10.00   17.00   17.00   17.00   10.00   17.00			O			O			
4.00			0			0			
5.00 6.00 7.00 8.00 9.00 10.00 11.00 Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  0 12.00 14.00 15.00 16.00 17.00				0		U			
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00  6.00 7.00 8.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		and trons (eredit adjustments) (specify)		0					
8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 0 13.00 14.00 15.00 16.00 17.00				0					
9.00 10.00   Total additions (sum of line 4-9)   0   10.00 11.00   Subtotal (line 3 plus line 10)   0   0   11.00 12.00   Deductions (debit adjustments) (specify)   0   12.00 14.00   15.00   0   15.00 16.00   17.00   0   17.00	7.00			0					7. 00
10.00   Total additions (sum of line 4-9)   0   10.00   11.00   12.00   12.00   13.00   14.00   15.00   15.00   16.00   17.00   17.00   17.00   10.00	8.00			0					8. 00
11.00   Subtotal (line 3 plus line 10)   0   11.00   12.00   13.00   14.00   15.00   15.00   16.00   17.00   17.00   10   10   10   10   10   10   10				0					
12. 00   Deductions (debit adjustments) (specify)			0			-			
13. 00 14. 00 15. 00 16. 00 17. 00			0			0			
14. 00       15. 00       16. 00       17. 00       17. 00		Deductions (debit adjustments) (specify)		0					
15. 00 16. 00 17. 00				0					
16. 00 17. 00				0					
17. 00				0					
				0					
18.00 Total deductions (sum of lines 12-17) 0 0 18.00		Total deductions (sum of lines 12-17)	0	Ĭ		0			
19.00 Fund balance at end of period per balance 0 0 19.00	19. 00		0			0			19. 00
sheet (line 11 minus line 18)		sheet (line 11 minus line 18)							

Health Financial Systems LUTH-STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150168

			10 12/31/2013	5/31/2016 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	20 4
	3337 331131 33331 pt 311	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	11.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	8, 285, 49	1	8, 285, 491	1. 00
2.00	SUBPROVIDER - I PF	1 3, 233, 11		0, 200,	2. 00
3.00	SUBPROVIDER - IRF				3. 00
4. 00	SUBPROVI DER				4. 00
5. 00	Swing bed - SNF		0	0	5. 00
6. 00	Swing bed - NF		0	0	
7. 00	SKILLED NURSING FACILITY			Ü	7. 00
8.00	NURSI NG FACI LI TY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	8, 285, 49	1	8, 285, 491	10.00
10.00	Intensive Care Type Inpatient Hospital Services	0, 200, 17	'	0, 200, 171	10.00
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	:	o	0	
10.00	11-15)			· ·	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 285, 49	1	8, 285, 491	17. 00
18. 00	Ancillary services	221, 451, 12		221, 451, 123	
19. 00	Outpati ent servi ces	· · · · · · · · · · · · · · · · · · ·	0 185, 315, 737	185, 315, 737	19. 00
20. 00	RURAL HEALTH CLINIC		0 0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY			o l	22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC			o l	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	st. 229, 736, 61	4 185, 315, 737	415, 052, 351	28. 00
20.00	G-3, line 1)	227,700,01		1.0,002,001	20.00
	PART II - OPERATING EXPENSES	- '			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		72, 304, 893		29. 00
30.00	ADD (SPECIFY)		o		30. 00
31.00			o		31. 00
32.00			o		32. 00
33.00			o		33. 00
34.00			o		34.00
35.00			o		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		o		37. 00
38. 00			o		38. 00
39. 00			ol		39. 00
40.00			o		40.00
41. 00			o		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nsfer	72, 304, 893		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems LUTHERAN MUSCULOSKELE	ETAL CENTER	In Lie	u of Form CMS-2	2552-10
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 150168 Period:				
			From 01/01/2015 To 12/31/2015	Date/Time Prep 5/31/2016 10:2	
1.00	T	202		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			415, 052, 351	1.00
2.00	Less contractual allowances and discounts on patients' accounts	i		314, 455, 812	
3.00	Net patient revenues (line 1 minus line 2)			100, 596, 539	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	5)		72, 304, 893	
5.00	Net income from service to patients (line 3 minus line 4)			28, 291, 646	5. 00
/ 00	OTHER I NCOME				/ 00
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	0.00
	9.00 Revenue from television and radio service				9. 00 10. 00
11. 00	10.00 Purchase di scounts				11. 00
	Rebates and refunds of expenses			0	12.00
12. 00 13. 00	Parking lot receipts			0	
	Revenue from laundry and linen service			0	
14. 00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other tha	in patrents		0	
17. 00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	1 / 1 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	21.00 Rental of vending machines				21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0 308, 239	23. 00 24. 00
	24.00 OTHER INCOME				
25. 00	Total other income (sum of lines 6-24)			308, 239	
	Total (line 5 plus line 25)			28, 599, 885	
	OTHER EXPENSES (SPECIFY) Total other expenses (sum of Line 27 and subscripts)			0	27. 00

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

28.00

28, 599, 885 | 29. 00

Heal th	Financial Systems LUTHERAN MUSCULOSKEL	ETAL CENTER	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150168	Peri od: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Pre 5/31/2016 10:	pared:
		Title XVIII	Hospi tal	PPS	25 4111
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPITAL FEDERAL AMOUNT			70/ 040	4 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			736, 948 0	
2.00	Capital DRG outlier payments			138	
2.00	Model 4 BPCI Capital DRG outlier payments			0	1
3. 00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	16. 27	
4. 00	Number of interns & residents (see instructions)	· · · · · · · · · · · · · · · · ·		0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	6. 00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A par	tient days (Worksheet E	, part A line	0. 00	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instructions)	tions)		0.00	8.00
9.00	Sum of Lines 7 and 8	tions)		0.00	
10. 00	Allowable disproportionate share percentage (see instructions)				10.00
11. 00	Disproportionate share adjustment (see instructions)			0.00	
12. 00	Total prospective capital payments (see instructions)		737, 086		
				1 00	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstances	s (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see ins	tructions)		0 0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary of		line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	cricumstances (Trie 2 x	. Title 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as applica	abl e)		0	
10. 00	Current year comparison of capital minimum payment level to cap		less line 9)	0	
11. 00	Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)			0	
12. 00	Net comparison of capital minimum payment level to capital payr	ments (line 10 nlus lin	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over cap			0	
	(if line 12 is negative, enter the amount on this line)		3 1		
15. 00	Current year allowable operating and capital payment (see inst	ructi ons)		0	
16. 00	Current year operating and capital costs (see instructions)			0	
17. 00	Current year exception offset amount (see instructions)			0	17. 00