Heal th Financi	al Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS	6-2552-10
This report is	s required by law (42 USC 1	395g; 42 CFR 413.20(b)). Fai	lure to report can res	ult in all interim	FORM APPROVE	ED
payments made	since the beginning of the	cost reporting period being	deemed overpayments (42 USC 1395g).	OMB NO. 0938	
			1		EXPIRES 05-3	31-2019
		X COST REPORT CERTIFICATION	Provider CCN: 15-0168	Peri od:	Worksheet S	
AND SETTLEMENT	SUMMARY			From 01/01/2016	Parts I-III Date/Time Pr	conarod
				10 12/31/2010	5/31/2017 9:	
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically fil	ed cost report		Date: 5/31/20	17 Time:	9:49 am
use only	2. [] Manually submitted					
	3.[0]If this is an amen 4.[F]Medicare Utilizati	ded report enter the number on. Enter "F" for full or "L	of times the provider _" for low.	resubmitted this co	ost report	
Contractor	5. [1]Cost Report Status			.NPR Date:		
use only		7. Contractor No.		. Contractor's Vendo		4
		it 8. [N]Initial Report fo 9. [N]Final Report for	this Provider CCN 12			
	(3) Settled with Audit			number of tim	les reopened	= 0-9.
	(4) Reopened(5) Amended					
	(5) Allended					
PART II - CERT	FI FI CATI ON					
MI SREPRESENTAT	TION OR FALSIFICATION OF AN	Y INFORMATION CONTAINED IN T	HIS COST REPORT MAY BE	PUNI SHABLE BY CRIM	AINAL, CIVIL	AND
ADMI NI STRATI VE	E ACTION, FINE AND/OR IMPRI	SONMENT UNDER FEDERAL LAW.	FURTHERMORE, IF SERVIC	ES IDENTIFIED IN TH	IS REPORT WE	RE
PROVIDED OR PR	ROCURED THROUGH THE PAYMENT	DIRECTLY OR INDIRECTLY OF A	KICKBACK OR WERE OTHE	RWISE ILLEGAL, CRIM	AINAL, CIVIL	AND

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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 (15-0168) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(Si gned)

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	21, 984	46, 891	0	521, 806	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	СМНС І	0		0		0	12.00
200.00	Total	0	21, 984	46, 891	0	521, 806	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.

Date

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	LUTHERAN MUS DENTIFICATION DATA			N: 15-0168		1:	V	of Forr Iorkshe		
							01/01/2 12/31/2	016 [Part I Date/Til		
	1.00	2.00)	3.00			4.	.00	5/31/20	17 9:4	1 am
	Hospital and Hospital Health Care Co										4 00
1.00 2.00	Street: 7952 W. JEFFERSON BLVD City: FORT WAYNE	PO Box: State: IN	Zip	Code: 468	04 Co	ounty:					1.00 2.00
		Component Name	e CCN	I CBS	SA Provi	der Da			t Syste		
			Numb	er Numb	er Typ	e Cert	fied	Т, V	0, or XVIII	N) XI X	
		1.00	2.0	0 3.0	0 4.0	0 5.	00	v 6. 00	7.00	8.00	
	Hospital and Hospital-Based Componen		4504				(0.0.0.0				
3.00	Hospi tal	LUTHERAN MUSCULOSKELETAL CE	NTFR 1501	68 2300	60 1	03/07	/2008	N	Р	0	3.00
4.00	Subprovider - IPF										4.00
5.00 5.00	Subprovider - IRF Subprovider - (Other)										5.00
7.00	Swing Beds - SNF										6.00 7.00
3.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
	Hospi tal -Based NF Hospi tal -Based OLTC										10.00
	Hospi tal -Based HHA										12.00
	Separately Certified ASC										13.00
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.00 15.00
	Hospital-Based Health Clinic - FQHC										16.00
	Hospital-Based (CMHC) Hospital-Based (CORF)										17.00
	Renal Dialysis										17.10 18.00
19.00	Other										19.00
							From: 1.00		<u> </u>		
20.00	Cost Reporting Period (mm/dd/yyyy)					01	/01/20	16	12/31/		20.00
1. 00	Type of Control (see instructions)						4				21.00
	Inpatient PPS Information Does this facility qualify and is it	currently receivin	na navments	for disp	roportion	ato	N				22.00
22.00	share hospital adjustment, in accord	2	0.5		•		IN I				22.00
	for yes or "N" for no. Is this facil				(c)(2)(Pi	ckl e					
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				t reporti	na	N		N		22.01
	period? Enter in column 1, "Y" for y	es or "N" for no fo	or the porti	on of th	e cost						
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period occ	un ning on t	a alter							
22.02	Is this a newly merged hospital that						Ν		Ν		22. 02
	determined at cost report settlement or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for										
<u>.</u>	or after October 1.	i a maal aani fi aati ar	from urbor	. to muno		out +	N		N		22.07
22.03	Did this hospital receive a geograph of the OMB standards for delineating						Ν		N		22.03
	in column 1, "Y" for yes or "N" for	no for the portion	of the cost	reporti	ng period						
	prior to October 1. Enter in column cost reporting period occurring on o										
	hospital contain at least 100 but no										
2 00	42 CFR 412.105)? Enter in column 3,			DE bolo	u la solu			0			
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							0			23.00
	method of identifying the days in th	is cost reporting p	period diffe	erent fro	m the met	hod					
	used in the prior cost reporting per			<u>for yes o</u> n-State	<u>r "N" for</u> Out-of	no. 0ut-o	f Me	di cai o	1 0+	her	
			Medicaid M	edi cai d	State	State	e HM	lo days		i cai d	
		p		ligible unpaid	Medi cai d				da	ays	
				days	paid days	s eligib unpai					
			1.00	2.00	3.00	4.00		5.00		. 00	
4.00	If this provider is an IPPS hospital		0	0		0	0		0	0	24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c	olumn 3,									
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
	If this provider is an IRF, enter th	e in-state	0	0		0	0		0		25.00
25.00		in stato									
25.00	Medicaid paid days in column 1, the										
25. 00	Medicald paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column	umn 2,									
25.00	Medicaid eligible unpaid days in col	umn 2, 3, out-of-state umn 4, Medicaid									

OSPI T	Financial Systems LUTHERAN MU AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA	Provider CC		eriod:	2017	Workshe	et S-2	2
					rom 01/01/2 o 12/31/2		Part I Date/Ti	me Pre	epared:
					Urban/Rura		5/31/20)17 9:4	<u>1 am</u>
					1.00		2. (1
6.00	Enter your standard geographic classification (not wa			inning of the		1			26.0
7.00	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	ge) sta "2" fo	atus at the end or rural. If ap	l of the cost plicable,		1			27.0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.0
					Begi nni n	ig:	Endi		
6.00	Enter applicable beginning and ending dates of SCH st	atus 9	Subscript Line	36 for number	1.00		2.0	00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.	•			0			37.0
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.0
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.0
	enter subsequent dates.				Y/N		Y/	N	
0.00	Dage this facility surlify for the state state		t odivete 1 d	ion Louis 1	1.00		2.0		20. 2
	Does this facility qualify for the inpatient hospital 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)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ice with 42 nstructions)			N		39.0
0. 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.	er 1. E	Enter "Y" for y		N		N		40. C
					-	V 1.00	XVIII) 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for a	li sproporti onat	e share in ac	cordance	N	N	N	45. 0
o. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.0
7.00 3.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N	N N	47.0 48.0
b. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	Ν			56. C
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th ", comp	"N" for no in his cost report plete Worksheet	i column 1. lf ing period?	column 1 Enter "Y"				57.0
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb			ins' services a	as				58.0
0 00	defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			D+ I		N			59.0
	Are you claiming nursing school and/or allied health					N			60.0
	provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	s or "N" for no IME	<u>. (see instru</u> Direct GME	ctions) IME		Di rect	t GME	
		1.00	2.00	3.00	4.00		5.0	00	
	Did your hospital receive FTE slots under ACA					0.00			61.0
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0. 00	0.0	o				61.0
02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care		0.00	0.0	n				61.0
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.0					
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. OC	0.0	d				61.0
. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	o				61.0
	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. OC	0.0	o				61. C

ISPITAL AND HOSPITAL HI	EALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provider CC		eriod:	Worksheet S-2	
					Fr	com 01/01/2016 0 12/31/2016	Part I Date/Time Pre 5/31/2017 9:4	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
.06 Enter the amount used for cap reli care or general s	ef and/or FTEs	that are nonprimary		0.00	0.00			61.(
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
specialty, if any for each new prog column 1, the pro program code, ent	, and the numbe ram. (see instr gram name, ente er in column 3, and enter in co	fy each new program r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME				0.00	0.00	61.
.20 Of the FTEs in li program specialty residents for eac instructions) Ent enter in column 2	ne 61.05, speci ; if any, and t h expanded prog er in column 1, , the program c weighted count	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0. 00	61. :
							1.00	
		Ith Resources and Ser						
		s that your hospital funding (see instruc		in this cost	reporting peri	od for which	0.00	62.
2.01 Enter the number during in this co	of FTE resident st reporting pe	s that rotated from a riod of HRSA THC proc sidents in Nonprovide	n Teachi gram. (s	see instruction		your hospital	0.00	62.
.00 Has your facility	trained reside	nts in nonprovider se umn 1. If yes, comple	ettings	during this co		eriod? Enter	N	63.0
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
		r FTE Residents in No uly 1, 2009 and befor			This base year	is your cost r	reporting	
.00 Enter in column 1 in the base year resident FTEs att settings. Enter resident FTEs tha	, if line 63 is period, the num ributable to ro in column 2 the t trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	y trair a-primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64. (
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
00 Enton in salur 1	16 11 (0	1.00		2.00	3.00	4.00	5.00	45
5.00 Enter in column 1 is yes, or your f trained residents year period, the associated with p FTEs for each pri program in which residents. Enter the program code, column 3, the num unweighted primar residents attribu rotations occurri	acility in the base program name rimary care mary care you trained in column 2, enter in ber of y care FTE table to				0.00	0.00	0. 000000	65.0

Heal th	Financial Systems	LUTHERAN M	USCULOSKELETAL CEN	ITER	In Lie	u of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provi dei	1	Period: From 01/01/2016 Fo 12/31/2016		pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTF Residents in	Nonnrovider Sett	1.00	2.00	3.00	
	beginning on or after July 1, 20	10	•		· · ·		
	Enter in column 1 the number of p FTEs attributable to rotations of Enter in column 2 the number of p FTEs that trained in your hospit;	ccurring in all nonpr unweighted non-primar	rovider settings. Ty care resident	0.0	0 0.00	0. 000000	66.00
	(column 1 divided by (column 1 +						
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	0 0.00	0. 000000	67.00
	Inpatient Psychiatric Facility P	PS			1.0	0 2.00 3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does it co	ontain an IPF sub	provider? N		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CFI Column 3: If column 2 is Y, india (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS	,04? Enter "Y" fo lity train reside (D)? Enter "Y" fo ear began during th	r yes or "N" for nts in a new teac r yes or "N" for his cost reportin	no. (see hing no. g period.	0	71.00
	ls this facility an Inpatient Re subprovider? Enter "Y" for yes a		(IRF), or does i	t contain an IRF	N		75.00
76.00	recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Enter indicate which program year began	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? En new teaching prog for no. Column 3:	ter "Y" for yes c ram in accordance If column 2 is Y	er "N" for with 42	0	76.00
						1.00	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.				period? Enter	N N	80.00 81.00
85.00 86.00	TEFRA Providers Is this a new hospital under 42 (Did this facility establish a new	w Other subprovider (excluded unit) une			N	85. 00 86. 00
87.00	§413.40(f)(1)(ii)? Enter "Y" fo Is this hospital a "subclause (I for yes or "N" for no.			(d) (1) (B) (i v) (I I)	? Enter "Y"	N	87.00
					V 1.00	XI X 2.00	
	Title V and XIX Services						
	Does this facility have title V a yes or "N" for no in the applical		hospital services	? Enter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for full or in part? Enter "Y" for ye	title V and/or XIX th			Ν	Y	91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	eds (dual certifi	cation)? (see		N	92.00
93.00	instructions) Enter "Y" for yes o Does this facility operate an IC	F/IID facility for pu			N	N	93.00
94.00	"Y" for yes or "N" for no in the Does title V or XIX reduce capit; applicable column.		or yes, and "N" fo	r no in the	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	SKELETAL CENTER Provider C		Period: From 01/01	/2016	u of Form Workshee Part I	t S-2	
			To 12/31.	/2016	Date/Tim 5/31/201		
			V		XI X		
05 00 If line 04 is "V", onter the reduction percentage in the an	plicable colum	2	1.00		2.00		95.0
 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. 			N N)	0. UC N		95.0 96.0
07.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0.00)	0.00)	97.0
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 of this facility qualifies as a CAH, has it elected the all-		hod of paymen	t				105. 0 106. 0
<pre>for outpatient services? (see instructions) 07.00 f this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.</pre>	n 1. (see inst	ructions) If	t			1	107. 0
08.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					-		108. 0
	Physi cal 1.00	Occupationa 2.00	I Speed 3.00		Respira 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					1	109. 0
10.00Did this hospital participate in the Rural Community Hospita	al Domonotrati	an nacioat (A	104 Domo) fo		1. OC N		110. 0
the current cost reporting period? Enter "Y" for yes or "N"				//			110. 0
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	. If column 2 nt for long te	is "E", enter rm care (incl	in column udes	N		0 1	115. 0
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu			"N" for	N N			116. 0 117. 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	is	1		1	118. 0
		D ·					
		Premi ums	Losse	es	Insura	nce	
18.01List amounts of malpractice premiums and paid losses:		1.00 100,9	2.00		1 nsura 3. 00)	118. C
18.01 List amounts of malpractice premiums and paid losses:		1.00	2.00) 17, 649) 0 1	118. C
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.		1.00 100,9 than the	<u> </u>) 17, 649	3. 00) 01) 1	118. 0
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 19.00 DO NOT USE THIS LINE	dule listing c d Harmless pro n column 1, "Y ualifies for t	1.00 100,9 than the ost centers vision in ACA " for yes or he Outpatient	46 1 1.00 N) 17, 649	3. 00) 01	118. C 119. C
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SPITAL AND HOSPITAL HEALTH CARE COMPLE	LUTHERAN MUSCULOS EX IDENTIFICATION DATA	Provider CCN	: 15-0168	Period:		u of Form CMS Worksheet S- Part I	
					2/31/2016		
					1.00	2.00	-
3.00 If this is a Medicare certified of			ation date		1.00	2.00	133. 0
in column 1 and termination date, 4.00 If this is an organ procurement or	rganization (OPO), enter t		ı column 1				134. C
and termination date, if applicabl All Providers							-
0.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	"N" for no in column 1. If	yes, and home c	office cost	ts	Y	449008	140. 0
					3.00		
If this facility is part of a chai			gh 143 the	name and		of the	
home office and enter the home off 1.00 Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WI			ctor's Nu	mber: 5228	0	141.0
2.00 Street: 4000 MERIDIAN BLVD	P0 Box:						142.
3.00 City: FRANKLIN	State: TN	1	Zip Coo	le:	3706	7	143.
						1 00	_
4.00 Are provider based physicians' cos	sts included in Worksheet	A?				1.00 Y	144.0
			2		1.00	2.00	
5.00 f costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc	" for yes or "N" for no in clude Medicare utilization	column 1. If co	olumn 1 is		Y	Ν	145.
period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the previo n column 1. (See CMS Pub.			f	N		146.
				I			
						1.00	
7.00Was there a change in the statisti							4 4 7
						N	147. 148
8.00 Was there a change in the order of	f allocation? Enter "Y" fo	r yes or "N" for	no.	or no.		N N N	148.
8.00 Was there a change in the order of	f allocation? Enter "Y" fo	r yes or "N" for nter "Y" for yes Part A	no. or "N" fo Part B	T	itle V	N N Title XIX	148.
8.00Was there a change in the order of 9.00Was there a change to the simplifi	f allocation? Enter "Y" fo ied cost finding method? E	r yes or "N" for nter "Y" for yes Part A 1.00	no. or "N" fo Part B 2.00	Т	3.00	N N Title XIX 4.00	148.
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 3. 00 Was there a change in the order of 2. 00 Was there a change to the simplific provides the simplific provides the simplific provides of the sinterprovides of the sinter simplific provide	f allocation? Enter "Y" fo ied cost finding method? E ider that qualifies for an "N" for no for each compon ampus hospital that has on Name	r yes or "N" for nter "Y" for yes Part A 1.00 exemption from ent for Part A a N N N N N N N N N County	no. or "N" for Part B 2.00 the appli nd Part B N N N N N N N N N N N N N	Ferent CB	3.00 The Iowe CFR §413 N N N N N N N N SAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 161.
 3. 00 Was there a change in the order of 2. 00 Was there a change to the simplified of 2. 00 Was there a change to the simplified of 2. 00 Was there a change to the simplified of 2. 00 Was there a change to the simplified of 2. 00 Was there a change to the simplified of 2. 00 Hospital 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 9. 00 SNF 9. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	f allocation? Enter "Y" fo ied cost finding method? En ider that qualifies for an "N" for no for each compon "N" for no for each compon nampus hospital that has on Name 0	r yes or "N" for nter "Y" for yes Part A 1.00 n exemption from ent for Part A a N N N N N N N N N N N N N N N N N N N	no. or "N" for Part B 2.00 the appli N N N N N N N N N N N N N	Ferent CB	3.00 The Iowe CFR §413 N N N N N N N N SAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N FTE/Campus 5.00	148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.
 3. 00 Was there a change in the order of 2. 00 Was there a change to the simplific provides the second state of the simplific provides the second state of th	f allocation? Enter "Y" fo ied cost finding method? En- ider that qualifies for an "N" for no for each compon ampus hospital that has on Name 0 1) incentive in the Americ	r yes or "N" for nter "Y" for yes Part A 1.00 exemption from ent for Part A a N N N N N N N N N N N N N N N N N N N	r no. r or "N" for Part B 2.00 the appli i nd Part B N N N N N N N N N N State 2 2.00 Rei nvestm	Ferent CB	3.00 The Iowe CFR §413 N N N N N N N N SAs? CBSA	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 157. 160. 161. 161. 165. 00 166.
 3. 00 Was there a change in the order of 2. 00 Was there a change to the simplific provides the second state of the simplifies of the second state of the sec	f allocation? Enter "Y" fo ied cost finding method? En- ider that qualifies for an "N" for no for each compon ampus hospital that has on Name 0 1) incentive in the Americ r under §1886(n)? Enter "	r yes or "N" for nter "Y" for yes Part A 1.00 exemption from ent for Part A a N N N N N N N N N N N N N N N Y Tor yes or "N	r no. r or "N" for Part B 2.00 the appli i N N N N N N N N N N N N N	Ferent CB Zip Code 3.00	3.00 the I owe 2 CFR §413 N N N N N N SAS? CBSA 4.00	N N Title XIX 4.00 rof costs .13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 157. 160. 161. 161. 165. 00 166. 100 166.
 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplific provides this facility contain a provior charges? Enter "Y" for yes or "5. 00 Hospital 6. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC 1. 10 CORF Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 	f allocation? Enter "Y" fo ied cost finding method? En- ider that qualifies for an "N" for no for each compon ampus hospital that has on Name 0 1) incentive in the Americ r under §1886(n)? Enter " 25 is "Y") and is a meanin HIT assets (see instructio	r yes or "N" for nter "Y" for yes Part A 1.00 exemption from ent for Part A a N N N N N N N N N N N N N N N N N N N	r no. s or "N" for Part B 2.00 the appli- nd Part B N N N N N N N N N N N N N	ferent CB Zip Code 3.00	3.00 The Iowe 2.CFR \$413 N N N N N SAs? CBSA 4.00 The	N N Title XIX 4.00 r of costs .13) N N N N N N N N N N N N N N N N N N N	148. 149. 155. 156. 157. 158. 157. 160. 161. 161. 165. 00 166.

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0168	Period: From 01/01/2016	Worksheet S-2 Part I	2
				Date/Time Pre	pared:
				5/31/2017 9:4	<u>1 am</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	inning date and ending dat	e for the reporting	01/01/2016	12/31/2016	170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provide	er have any days for indiv	iduals enrolled in	N	(171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, er	nter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

JSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Date/Time Pr 5/31/2017 9:	epared:
				Y/N	Date 2,00	
	General Instruction: Enter Y for all YES responses. Enter N 1 mm/dd/yyyy format.	for all NO re	esponses. Ent	1.00 er all dates in t	2.00 he	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hogi ppi pg of	the cost	N		1 1 00
00	reporting period? If yes, enter the date of the change in co	lumn 2. (see	instructions			1.00
		`	Y/N	Date	V/I	
00	Hee the provider terminated participation in the Madiagra Dr	agrom2 lf	1.00	2.00	3.00	2.00
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	3, "V" for	N			2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug r or its the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Daparts		1.00	2.00	3.00	-
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	r Compiled, lable in	N			4.00
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reco		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider i	s N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		d during the	N N		7.00 8.00
00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		cal education	N		9.00
D. 00	Was an approved Intern and Resident GME program initiated or		the current	Ν		10.00
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.00
					Y/N 1.00	
	Bad Debts					
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po period? If yes, submit copy.			ost reporting	N N	12.00 13.00
4. 00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	ts waived? If	°yes, see in	structions.	N	14.00
5.00	Did total beds available change from the prior cost reportin	<u>v</u> 1	yes, see ins ⁻ t A	tructions. Par	N t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
o. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Ν		N		16.00
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.00
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		N		18.00
9. 00	but are not 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 other PS&R Report information? If yes, see instructions.	Ν		Ν		19.00

Health Financial Systems

	LUTHERAN	MUSCULOSKELETAL	CENTER
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In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016		repared:
		Doscr	i pti on	Y/N	Y/N	. 41 am
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
	The point data for other : Deserve the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21 00	Was the cost report prepared only using the provider's	N 1.00	2.00	N	4.00	21.00
	records? If yes, see instructions.					21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)		1100	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	od into during	this cost ro	porting poriod?		24.00
24.00	If yes, see instructions	eu mito during	this cost re	por tring period?		24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period?	lfyes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost reporti	ng period? I	f yes, see		26.00
27.00	instructions. Has the provider's capitalization policy changed during th	o cost roportir	a poriod2 lf	vos submit		27.00
27.00	copy.	le cost reportin		yes, subili t		27.00
	Interest Expense					
28.00	Were new Loans, mortgage agreements or letters of credit e	entered into dur	ing the cost	reporting		28.00
20.00	period? If yes, see instructions.	band funda (Da	bt Corvios D	locorus Fund)		20.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service R	eserve Fund)		29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes	, see		30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ves	see		31.00
	instructions.			,		
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through co	ntractual		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If		33.00
	no, see instructions.		5	5		
	Provi der-Based Physi ci ans				-	
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement with	n provider-ba	sed physi ci ans?		34.00
35.00	If line 34 is yes, were there new agreements or amended ex	kisting agreemer	nts with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see i			·	-	
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
36 00	Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			37.00
38 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	,		38.00
50.00	the provider? If yes, enter in column 2 the fiscal year en					50.00
39.00	If line 36 is yes, did the provider render services to oth					39.00
40 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfves see			40.00
40.00	instructions.					40.00
		1	00	2	00	_
	Cost Report Preparer Contact Information	1.	00	2.	00	
41.00	Enter the first name, last name and the title/position	SHERI		A		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
12 00	respectively.	COMMUNITY HEAL	TU SVSTEMS			12.00
42.00	Enter the employer/company name of the cost report preparer.	CONNUNT IY HEAL	IN SISIEMS			42.00
43.00	Enter the telephone number and email address of the cost	615-465-7101		SHERI _PRI CE@CH	S. NET	43.00
	report preparer in columns 1 and 2, respectively.			l		

Heal th	Financial Systems LUTHERAN MUSCU	LOSKELETAL CENTER	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0168	Period: From 01/01/2016	Worksheet S-2 Part II			
			To 12/31/2016		pared: 1 am		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	PRI CE			41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016		
						5/31/2017 9:4 I/P Days / 0/P	
						<u>Visits / Trips</u>	
	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, 27		0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		39	14, 27	0.00	0	7.00
0.00	beds) (see instructions)	01.00					
8.00	INTENSIVE CARE UNIT	31.00	0		0 0.00		8.00
9.00	CORONARY CARE UNIT	32.00	0		0 0.00		
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00		
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0 0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00				0	12.00
13.00 14.00	NURSERY	43.00	39	14.0	0.00		13.00 14.00
14.00	Total (see instructions) CAH visits		39	14, 27	0.00		14.00
16.00	SUBPROVIDER - IPF	40, 00	0		0		16.00
17.00	SUBPROVIDER - IRF	40.00	0		0	0	
18.00	SUBPROVI DER	41.00	0		0	0	17.00
19.00	SKILLED NURSING FACILITY	44.00	o		0	0	
20.00	NURSING FACILITY	45.00	0		0	0	
21.00	OTHER LONG TERM CARE	46.00	0		0		21.00
22.00	HOME HEALTH AGENCY	101.00			0	0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.00
24.00	HOSPICE	116.00	o		0		24.00
24.10	HOSPICE (non-distinct part)	30.00			-		24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99. 10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		39				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	2, 209	405	6, 364			1.00
. 00	HMO and other (see instructions)	1, 326	0				2.00
. 00	HMO I PF Subprovi der	0	0				3.00
. 00	HMO I RF Subprovi der	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5.00
. 00	Hospital Adults & Peds. Swing Bed NF	-	0	0			6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 209	405	6, 364			7.00
. 00	INTENSIVE CARE UNIT	0	0	C			8.0
. 00	CORONARY CARE UNIT	0	0	C			9.0
0. OO	BURN INTENSIVE CARE UNIT	0	0	C			10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T	0	0	C			11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		0	C			13.0
4.00	Total (see instructions)	2, 209	405	6, 364	0.00	230. 15	
5.00	CAH visits	0	0	C			15.0
6.00	SUBPROVIDER - IPF	0	0	C	0.00	0.00	16.0
7.00	SUBPROVIDER - IRF	0	0	C	0.00	0.00	17.0
8.00	SUBPROVI DER						18.0
9. 00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	19.0
0. OO	NURSING FACILITY		0	C		0.00	20.0
1.00	OTHER LONG TERM CARE			C	0.00	0.00	21.0
2.00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23.0
4.00	HOSPICE	0	0	C	0.00	0.00	24.0
4. 10	HOSPICE (non-distinct part)	0	0	C			24.
5.00	СМНС – СМНС	0	0	C	0.00	0.00	25.0
5. 10	CMHC - CORF	0	0	C	0.00	0.00	25.1
6.00	RURAL HEALTH CLINIC	0	0	C	0.00	0.00	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26.2
7.00	Total (sum of lines 14-26)				0.00	230. 15	27.0
3. 00	Observation Bed Days		0	201			28.0
9.00	Ambulance Trips	0					29.0
0. 00	Employee discount days (see instruction)			C			30.0
1.00	Employee discount days - IRF			C			31. (
2.00	Labor & delivery days (see instructions)	0	0	C			32.0
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)			C			32.0
3.00	LTCH non-covered days	0					33.

iospi 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/31/2017 9:4	pared:
		Full Time Equivalents		Di s	scharges	·	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
00	Hospital Adults & Peds (columns 5 6 7 and	11.00					1.00
2.00 3.00 4.00 5.00 5.00 7.00 3.00 7.00 3.00 7.00 3.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 2.00 3.00 4.00 5.00 2.00 3.00 4.00 5.00 2.00 2.00 3.00 4.00 5.00 2.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	C C C C	9	21 142 0 0 0 0 0 0 0 0 0 0	2, 832 2, 832 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 25.00 25.10 25.10
26.00	RURAL HEALTH CLINIC	0.00					26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambulance Trips						29. (
0.00	Employee discount days (see instruction)						30. (
1. 00	Employee discount days - IRF						31.
32.00	Labor & delivery days (see instructions)						32.
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.0
3 00	LTCH non-covered days						33.

	Financial Systems AL WAGE INDEX INFORMATION	LUI	TIERAN MOSCOLO.	SKELETAL CENTER Provider CC	N: 15-0168 P	eriod:	worksheet S-3	
						rom 01/01/2016 o 12/31/2016	Date/Time Pre	
		Worksheet A Line Number		Reclassi fi cati	Adjusted		5/31/2017 9:4 Average Hourly	
		Li ne Nulliber		on of Salaries (from Warkshaat A ()	Sal ari es (col . 2 ± col .	Salaries in	Wage (col. 4 ÷ col. 5)	
		1.00	2.00	Worksheet A-6) 3.00	3) 4.00	col. 4 5.00	6.00	
	PART II - WAGE DATA SALARIES							-
. 00	Total salaries (see instructions)	200. 00	13, 449, 377	0	13, 449, 377	478, 718.00	28.09	1.00
. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
. 00	B Physician-Part A -		0	0	0	0.00	0.00	4.00
. 01	Administrative Physicians - Part A - Teaching		0	0	0			
. 00	Physician and Non Physician-Part B		0	0	0			5.00
. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
. 00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
. 01	Contracted interns and residents (in an approved		0	0	C	0.00	0. 00	7.01
. 00	programs) Home office and/or related organization personnel		0	0	0			
. 00 D. 00	SNF Excluded area salaries (see instructions)	44.00	0 1, 085, 940	0 103, 932	0 1, 189, 872	0.00 52,224.00		
1.00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 335, 846	0	1, 335, 846	3, 659. 00	365.08	11.00
2. 00	Care Contract Labor: Top Level		1,000,010	0	1, 000, 010			12.00
2.00	management and other management and administrative		Ū		Ŭ	0.00	0.00	12.00
3. 00	services Contract Labor: Physician-Part A - Administrative		33, 946	0	33, 946	196.00	173. 19	13.00
4. 00	Home office and/or related orgainzation salaries and		0	0	C	0.00	0.00	14.00
	wage-related costs Home office salaries		1, 597, 223	0	1, 597, 223			14.01
4. 02 5. 00	Related organization salaries Home office: Physician Part A		0 0	0	0	0.00 0.00		14.02 15.00
6. 00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS	[
7.00	Wage-related costs (core) (see instructions)		2, 944, 197	0	2, 944, 197			17.00
8.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
9.00 0.00	Èxcluded areas Non-physician anesthetist Part		341, 066 0	0	341, 066 0			19.00
1.00	A Non-physician anesthetist Part		0	0	0			21.00
	B Physician Part A -		0	0	0			22.00
2. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
3. 00	Physician Part B		0	0	0			23.00
4.00 5.00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0	0	0			24.00 25.00
5. 50	approved program) Home office wage-related		0	0	0			25.50
5. 51	Related orgainzation wage-related		0	0	0			25. 51
5. 52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25. 52
5. 53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25. 53
	OVERHEAD COSTS - DIRECT SALARIE					1	I	1
< < < > < < < < < < < < < < < < < < <	Employee Benefits Department	4.00	0	0	0 2, 254, 772		0.00	26.00

Heal th	Financial Systems	LUT	HERAN MUSCULOS	SKELETAL CENTER	R	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016 Fo 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number		on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	(0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	46, 478	0	46, 47	3 1, 741. 00	26. 70	30.00
31.00	Laundry & Linen Service	8.00	0	0		0.00	0.00	31.00
32.00	Housekeepi ng	9.00	0	0	(0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.00
34.00	Dietary	10.00	0	0	(0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		78, 023	0	78, 02	6, 247. 00	12. 49	35.00
36.00	Cafeteri a	11.00	0	0	(0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	207, 114	192, 560	399, 67	1 7, 766. 00	51.46	38.00
39.00	Central Services and Supply	14.00	401, 439	0	401, 43	23, 645. 00	16. 98	39.00
40.00	Pharmacy	15.00	288	0	28	5.00	57.60	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0	(0.00	0.00	41.00
42.00	Social Service	17.00	0	0	(0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	(0.00		43.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER				In Lieu of Form CMS-2552-10		
HOSPITAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2016 To 12/31/2016		
	Worksheet A		Recl assi fi cati			Average Hourly	
	Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
			(from	(col.2 ± col.		col. 5)	
			Worksheet A-6)		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		13, 527, 400	0	13, 527, 40	0 484, 965. 00	27.89	1.00
instructions)							
2.00 Excluded area salaries (see instructions)		1, 085, 940	103, 932	1, 189, 87	2 52, 224. 00	22. 78	2.00
3.00 Subtotal salaries (line 1		12, 441, 460	-103, 932	12, 337, 52	8 432, 741. 00	28, 51	3.00
minus line 2)		12, 441, 400	- 103, 932	12, 337, 32	432,741.00	20. 51	3.00
4.00 Subtotal other wages & related		2, 967, 015	0	2, 967, 01	5 50, 151. 00	59. 16	4.00
costs (see inst.)							
5.00 Subtotal wage-related costs (see inst.)		2, 944, 197	0	2, 944, 19	7 0.00	23.86	5.00
6.00 Total (sum of lines 3 thru 5)		18, 352, 672	-103, 932	18, 248, 74	0 482, 892. 00	37.79	6.00
7.00 Total overhead cost (see		3, 284, 606					7.00
i nstructi ons)		-, ,					

HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0168 Period: From 01/01/2016 To 12/31/2016 Worksheet 5-3 Part I V bate/Time Prepared: 5/3/2017 6.41 an Amount PART IV - WAGE RELATED COSTS Part IV - WAGE RELATED COSTS Worksheet 5-3 Part IV bate/Time Prepared: 5/3/2017 6.41 an Amount Mount Part IV - WAGE RELATED COSTS Part A - Core List Period: 000 Monguei Field Defined Benefit Pian Cost (see instructions) 0 236.565 0.00 Tax Sheltered Amulty (TSA) Employer Contribution 000 Longuei Field Defined Benefit Pian Cost (see instructions) 0 200 0.00 MANNI NISTRATIVE COSTS Cold to External Organization) 0 4.00 0.00 MANNINI STRATIVE COSTS Cold to External Organization) 0 5.00 5.00 Health Insurance (Purchased or Self Funded) 0 6.00 0.01 Health Insurance (Purchased or Self Funded) 0 8.01 8.00 Health Insurance (Purchased) 0 0 8.01 8.01 Health Insurance (Purchased) 0 0 8.01 8.00 Prescription Drug Plan 0 0 8.01 8.01 9.00 Prescription Drug Plan 0 0 8.02 9.00 9.00 9.00 9.00<	Heal th	Financial Systems LUTHERAN MUSCULOSKE	ELETAL CENTER	In Lie	u of Form CMS-2	2552-10
PART IV WGE RELATED COSTS Part IV WGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 236,565 0.00 Nonquali fied Defined Benefit Pian Cost (see instructions) 0 0.00 Unified Defined Benefit Pian Cost (see instructions) 0 0.00 Light Addministration fees 0 0.00 Legal /Accounting/Management Fees-Pension Plan 0 0.01 Health Insurance (Purchased or Self Funded) 1,779,566 0.01 Health Insurance (Furchased or Self Funded) 1,779,566 0.01 Benefic Pianded without a Third Party Administrator) 0 0.01 Legit Accounting and Vision Plan 0 0.01 Engle of the model with a Third Party Administrator) 8.00 8.02 Health Insurance (Purchased) 0 8.00 9.00 Health Insurance (If employee is owner or beneficiary) 12,070 0 10.00 Densition Plan 0 2.00 12.000 10.00	HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0168	From 01/01/2016	Part IV Date/Time Pre	pared:
PART IV - WGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 1.00 401K Employer Contributions 236,565 2.00 1.00 400K Employer Contributions 236,565 2.00 1.00 4.00 Data If led Defined Benefit P Ian Cost (see instructions) 0 0.01 0.02 0.02 0.03 0.04.00 0.04.01 Field Molin Nistration Fees 0.05 0.01 0.02 0.02 1.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
PART IV WAGE RELATED COSTS Part IV WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 3.00 Nonqual if ed Defined Benefit P Ian Cost (see instructions) 0 0.00 Unified Defined Benefit P Ian Cost (see instructions) 0 0.00 Ligal Accounting/Management Fees-Pension PI an 0 0.01 Legal /Accounting/Management Fees-Pension PI an 0 0.01 Ligal /Accounting/Management Fees-Pension PI an 0 0.01 Legal /Accounting/Management Fees-Pension PI an 0 0.01 Ligal /Accounting/Management Fees 0 0.02 Ligal /Accounting/Management Fees 0 0.03 Health Insurance (Purchased or Self Funded) 1, 779, 566 8.01 Basing and this tratarion 0 8.01 0.03 Health Insurance (Purchased) 0 8.02 0.04 Legal /Accounting and Vision Plan 1, 779, 566 8.00 0.03 Health Insurance (Self Funded with a Third Party Administrator) 0 8.02 0.0						
Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 236,565 0.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 0.00 Nonquali Fied Defined Benefit Plan Cost (see instructions) 0 0.01 Auguali Fied Defined Benefit Plan Cost (see instructions) 0 0.02 Auguali Fied Defined Benefit Plan Cost (see instructions) 0 0.01 Value Plant Administration Fees 0 0.01 Call Accounting/Management Fees-Pension Plan 0 0.01 Employee Managed Care Program Admin istration Fees 0 0.02 Health Insurance (Purchased or Self Funded) 1, 779, 566 8.00 Health Insurance (Self Funded with a Third Party Administrator) 0 8.00 8.01 Health Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.01 Health Insurance (If employee is owner or beneficiary) 0 8.02 0.00 Description Drug Plan 0 9.00 0.01 Out of Insurance (If employee is owner or beneficiary) 0 8.02 0.01 Out of Insurance (If employee is owner or beneficiary) 0 12.00		PART IV - WAGE RELATED COSTS			1.00	
RETIREMENT COST 236,565 1.00 401K Employer Contributions 236,565 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 3.00 Nonqual if ed Defined Benefit P lan Cost (see instructions) 0 4.00 Qualified Defined Benefit P lan Cost (see instructions) 0 4.00 Qualified Defined Benefit P lan Cost (see instructions) 0 0.00 Defined Benefit P lan Cost (see instructions) 0 0.01 MAMINISTRATIVE COSTS (Paid to External Organization) 0 0.01 Degit Accounting/Management Fees-Pension PI an 0 0.01 Employee Managed Care Program Administration Fees 0 0.01 Heal th Insurance (Furchased or Self Funded) 1,779,566 0.01 Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.00 0.02 Heal th Insurance (Self Funded with a Third Party Administrator) 0 8.02 0.02 Heal th Insurance (If employee is owner or beneficiary) 0 8.02 0.03 Description Drug Plan 0 9.00 11.00 0.01 Life Insurance (If employee is owner or beneficiary) 0 11.00						
2.00Tax Shei tered Annui ty (TSA) Employer Contribution02.003.00Nonquali fied Defined Benefit Plan Cost (see instructions)03.004.00Quali fied Defined Benefit Plan Cost (see instructions)04.00PLAN ADMINISTRATIVE COSTS (Paid to External Organization)05.005.00GUK/TSA Plan Administration fees06.006.00Legal /Accounting/Management Fees-Pension Plan06.007.00Employee Managed Care Program Administration Fees07.00HEALTH AND INSURANCE COST1, 779, 5668.008.00Health Insurance (Self Funded wi thout a Third Party Administrator)08.008.01Health Insurance (Self Funded wi thout a Third Party Administrator)08.008.02Health Insurance (Self Funded wi thout a Third Party Administrator)08.008.03Health Insurance (Pirchased)08.009.00Prescription Drug Plan09.0010.00Life Insurance (If employee is owner or beneficiary)1, 207012.0011.00Lise Insurance (If employee is owner or beneficiary)3, 18413.0012.00Nerkers' Compensation Insurance15.0016.0010.00Nerkers' Compensation Insurance17.0716.0011.00Nerkers' Compensation Insurance17.0716.0012.00Nerkers' Compensation Insurance17.0016.0013.00Nerkers' Compensation Insurance17.0016.0014.00Nerkers' Compensation On						
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 0 0.00 <td>1.00</td> <td>401K Employer Contributions</td> <td></td> <td></td> <td>236, 565</td> <td>1.00</td>	1.00	401K Employer Contributions			236, 565	1.00
4.00Qualified Defined Benefit Plan Cost (see instructions)04.00PLAN ADMINISTRATIVE COSTS (Paid to External Organization)5.00AOIK/TSA Plan Administration Fees05.006.00Legal/Accounting/Management Fees-Pension Plan06.006.0000Legal/Accounting/Management Fees-Pension Plan07.00mell bit Insurance (Purchased or Self Funded)1,779,5668.008.00Heal th Insurance (Self Funded without a Third Party Administrator)08.018.01Heal th Insurance (Self Funded with a Third Party Administrator)08.028.03Heal th Insurance (Purchased)08.039.00Prescription Drug Plan08.030.00Dental, Hearing and Vision Plan12.070010.00Life Insurance (If employee is owner or beneficiary)012.00711.00Life Insurance (If employee is owner or beneficiary)012.00712.00Disability Insurance (If employee is owner or beneficiary)014.0013.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0014.00Norkers' Compensation Insurance017.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.17.0017.00FicA-Employers Portion Only17.0118.0018.00Unemployment Insurance019.0019.00Vorkers' Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Instructions))	2.00				0	2.00
PLAN ADMI NISTRATIVE COSTS (Paid to External Organization)5.00401K/TSA PI an Administration fees6.00Legal /Accounting/Management Fees-Pension PI an7.00Employee Managed Care Program Administration Fees8.00Heal th Insurance (Purchased or Self Funded)8.00Heal th Insurance (Sel F Funded without a Third Party Administrator)8.01Heal th Insurance (Sel F Funded without a Third Party Administrator)8.02Heal th Insurance (Sel F Funded with a Third Party Administrator)8.03Heal th Insurance (Purchased)9.04Pescription Drug PI an00Dental, Hearing and Vision PI an01Life Insurance (If employee is owner or beneficiary)01Lige Insurance (If employee is owner or beneficiary)02Disability Insurance (If employee is owner or beneficiary)01Disability Insurance (If employee is owner or beneficiary)01O01Nor Curren Insurance (If employee is owner or beneficiary)01O02Nor current Insurance03Non current Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non current Insurance03Non current Insurance04Distate or Federal Unemployment Taxes OTHER04Care Taxes - Employers Portion Only17.7017.70818.00Medi care Taxes - Employers Portion Only17.7017.70818.00Medi care Taxes - Employers Portion Only17.7017.70818.00Medi care Taxes - Employers Portion O	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
5.00401K/TSA PI an Administration fees06.00Legal /Accounting/Management Fees-Pension PI an07.00Employee Managed Care Program Administration Fees07.00HEALTH AND INSURANCE COST08.01Heal th Insurance (Vertexased or Sel F Funded)1,779,5668.01Heal th Insurance (Sel F Funded wi thout a Third Party Administrator)08.02Heal th Insurance (Sel F Funded wi tha Third Party Administrator)08.02Heal th Insurance (Perchased)08.03Heal th Insurance (Perchased)09.00Prescription Drug Plan010.00Life Insurance (If employee is owner or beneficiary)1,207010.00Long-Term Care Insurance (If employee is owner or beneficiary)011.00Ling-Term Care Insurance (If employee is owner or beneficiary)012.00Workers' Compensation Insurance015.00"Workers' Compensation Insurance017.00FI CA-Employers Portion Only757,28917.00FI CA-Employers Portion Only177,10818.00Wedi care Taxes - Employers Portion Only18.0010.00Uberployment Insurance010.00State or Federal Unemployment Taxes25.00301.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see11.0010.00Taxes023.00210.01Taxes023.00210.02Day Care Cost and Allowances023.00210.	4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
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 1,779,566 8.00 8.00 Health Insurance (Purchased or Self Funded) 1,779,566 8.00 8.01 Health Insurance (Self Funded with a Third Party Administrator) 0 8.01 8.02 Health Insurance (Self Funded with a Third Party Administrator) 0 8.02 8.03 Health Insurance (Purchased) 0 8.03 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 12.070 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 12.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 14.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 14.00 10.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 10.00 Morkers' Compensation Insurance 0 17.00 177.108 18.00 19.00		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
7.00Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST07.00HEALTH AND INSURANCE COST HEALTH AND INSURANCE COST1,779,5568.008.00Health Insurance (Purchased or Self Funded)1,779,5568.018.01Health Insurance (Self Funded without a Third Party Administrator)08.018.02Health Insurance (Self Funded without a Third Party Administrator)08.018.03Health Insurance (Purchased)08.029.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan12,07010.0011.00Life Insurance (If employee is owner or beneficiary)11.0012,07012.00Accident Insurance (If employee is owner or beneficiary)3,18413.0013.00Disability Insurance (If employee is owner or beneficiary)3,18413.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)14.0015.0016.00Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)15.0015.0017.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only757,28917.0019.00Unemployment Insurance019.0000State or Federal Unemployment Taxes25.00320.0001ODay Care Cost and Allowances022.0001Day Care Cost and Allowances022.0002.00 <td>5.00</td> <td>401K/TSA Plan Administration fees</td> <td></td> <td></td> <td>0</td> <td>5.00</td>	5.00	401K/TSA Plan Administration fees			0	5.00
HEALTH AND INSURANCE COST8.00Heal th Insurance (Purchased or Self Funded)8.01Heal th Insurance (Self Funded wi thout a Third Party Administrator)8.01Heal th Insurance (Self Funded wi tha Third Party Administrator)8.02Heal th Insurance (Self Funded wi that a Third Party Administrator)8.03Heal th Insurance (Self Funded wi that a Third Party Administrator)8.04Heal th Insurance (Self Funded wi that a Third Party Administrator)8.05Nearch State (Purchased)9.00Prescription Drug Plan00Dental, Hearing and Vision Plan1.00Life Insurance (If employee is owner or beneficiary)1.00Life Insurance (If employee is owner or beneficiary)1.00Disability Insurance (If employee is owner or beneficiary)1.00Long-Term Care Insurance (If employee is owner or beneficiary)1.00Norkers' Compensation Insurance1.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.1.00Nor cumulative portion)1.100IT7. 1081.00State or Federal Unemployment Taxes0.01State or Federal Unemployment Taxes0.01State or Federal Unemployment Taxes0.01No State or Cost and Allowances0.00Day Gare Cost and Allowances0.01State or Federal Unemployment State0.02.00Tuit in Reimbursement0.03.00Tuit on Reimbursement0.04State or Federal Unemployment State0.05Tuit on Reimbursement0.00 <td>6.00</td> <td></td> <td></td> <td></td> <td>0</td> <td>6.00</td>	6.00				0	6.00
8.00Heal th Insurance (Purchased or Sel f Funded)1,779,5668.008.01Heal th Insurance (Sel f Funded with a Third Party Administrator)08.018.02Heal th Insurance (Sel f Funded with a Third Party Administrator)08.028.03Heal th Insurance (Purchased)08.029.00Prescription Drug Plan09.0010.00Dental , Hearing and Vision Plan1,207010.0011.00Life Insurance (If employee is owner or beneficiary)9,50711.0012.00Accident Insurance (If employee is owner or beneficiary)014.0013.00Disability Insurance (If employee is owner or beneficiary)014.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance015.0010.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.0017.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only757,28917.0019.00Unemployment Insurance019.0000State or Federal Unemployment Taxes25,00320.0001HERO22.0023.0022.0022.00Day Care Cost and Allowances022.0023.0023.00Tuition Reimbursement3,210,32624.0024.00Total Wage Related cost (Sun of Lines 1 -23)3,210,32624.00	7.00				0	7.00
8.01Heal th Insurance (Sel F Funded without a Third Party Administrator)08.018.02Heal th Insurance (Sel F Funded with a Third Party Administrator)08.028.03Heal th Insurance (Ururchased)08.029.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan12,07010.0011.00Life Insurance (If employee is owner or beneficiary)9,50711.0012.00Accident Insurance (If employee is owner or beneficiary)012.0013.00Disability Insurance (If employee is owner or beneficiary)014.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance014.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)17.0017.0017.00FICA-Employers Portion Only757,28917.0018.00Medi care Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes25,00320.0001HER21.00Lacctive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))21.0022.00Day Care Cost and Allowances023.0023.00Tuition Reinbursement03,210,32624.00Total Wage Related cost (Sum of Lines 1 -23)3,210,32624		HEALTH AND INSURANCE COST				
8.02Heal th Insurance (Sel f Funded with a Third Party Administrator)08.028.03Heal th Insurance (Purchased)08.039.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan12,07010.0011.00Life Insurance (If employee is owner or beneficiary)9,50711.0012.00Accident Insurance (If employee is owner or beneficiary)3,18413.0013.00Disability Insurance (If employee is owner or beneficiary)3,18413.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00Workers' Compensation Insurance210,03415.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.0017.00FICA-Employers Portion Only177,10818.0018.00Medicare Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance25.00320.000OTHER25.00320.0021.0022.00Day Care Cost and Allowances021.0023.00Tuition Reimbursement023.0023.0024.00Tuition Reimbursement3,210,32624.0024.00Tuition Reimbursement3,210,32624.00	8.00				1, 779, 566	8.00
8.03Heal th Insurance (Purchased)08.039.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan12,07010.0011.00Life Insurance (If employee is owner or beneficiary)9,50711.0012.00Accident Insurance (If employee is owner or beneficiary)9,50711.0013.00Disability Insurance (If employee is owner or beneficiary)3,18413.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance210,03415.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.0017.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only177,10818.0019.00State or Federal Unemployment Taxes021.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see021.0022.00Day Care Cost and Allowances022.0023.0023.0022.0023.00Tuition Reimbursement023.0023.0023.0024.0024.00Total Wage Related cost (Sum of Lines 1 -23)3,210,32624.0024.00	8.01				0	8.01
9.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan12,07010.0011.00Life Insurance (If employee is owner or beneficiary)9,50711.0012.00Accident Insurance (If employee is owner or beneficiary)012.0013.00Disability Insurance (If employee is owner or beneficiary)3,18413.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance210,03455.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.16.0017.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes021.000Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see021.0022.00Day Care Cost and Allowances021.0021.0023.00Tuit in Reimbursement023.0023.0023.0024.00Total Wage Related cost (Sum of lines 1 -23)3,210,32624.0024.00Part B - Other than Core Related Cost24.0024.00			or)		0	8. 02
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16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 0 16.00 17.00 FICA-Employers Portion Only 757,289 17.00 18.00 Medicare Taxes - Employers Portion Only 177.08 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 25,003 20.00 0THER 0 21.00 22.00 21.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 instructions)) 22.00 22.00 22.00 Day Care Cost and Allowances 0 23.00 23.00 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,210,326 24.00 24.00			()			
Non cumulative portion) TAXES17.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes25,00320.00OTHER019.0021.0021.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see021.0022.00Day Care Cost and Allowances022.0023.0023.00Tuit ion Reimbursement023.0023.0024.00Total Wage Related cost (Sum of Lines 1 -23)3,210,32624.00						
TAXES17.00FICA-Employers Portion Only757,28918.00Medicare Taxes - Employers Portion Only177,10818.00Unemployment Insurance020.00State or Federal Unemployment Taxes25,0030OTHER21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see021.00Day Care Cost and Allowances022.00Day Care Cost and Allowances023.00Tuition Reimbursement024.00Total Wage Related cost (Sum of Lines 1 -23)3, 210, 326Part B - Other than Core Related Cost0	16.00		ordinary accrual require	ed by FASB 106.	0	16.00
17.00FICA-Employers Portion Only757,28917.0018.00Medicare Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes25,00320.00OTHER21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0023.00Tuition Reimbursement023.0024.00Part B - Other than Core Related Cost3,210,326						
18.00Medicare Taxes - Employers Portion Only177,10818.0019.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes25,00320.00OTHER21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))21.0022.00Day Care Cost and Allowances022.0023.00Tuit ion Reimbursement023.0024.00Part B - Other than Core Related Cost3,210,326	17 00				757 000	17 00
19.00Unemployment Insurance019.0020.00State or Federal Unemployment Taxes25,00320.00OTHER021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0022.0023.00Total Wage Related cost (Sum of Lines 1 -23)3,210,32624.00Part B - Other than Core Related Cost024.00						
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OTHER 0 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 22.00 Day Care Cost and Allowances 0 23.00 Tuition Reimbursement 0 24.00 Total Wage Related cost (Sum of Lines 1 -23) 3, 210, 326 Part B - Other than Core Related Cost 0					-	
21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0023.00Tuition Reimbursement023.0024.00Total Wage Related cost (Sum of Lines 1 -23)3,210,326Part B - Other than Core Related Cost024.00	20.00				25,003	20.00
instructions)) 22.00 23.00 24.00 Part B - Other than Core Related Cost instructions)) Day Care Cost and Allowances 0 22.00 23.00 24.00 24.00	21 00		Penarted on lines 1 throu	igh 1 above (see	0	21 00
22.00Day Care Cost and Allowances022.0023.00Tuition Reimbursement023.0024.00Total Wage Related cost (Sum of lines 1 -23)3,210,326Part B - Other than Core Related Cost	21.00		tepor teu on rifles i thiot	igii 4 above. (see	0	21.00
23.00Tuition Reimbursement023.0024.00Total Wage Related cost (Sum of lines 1 -23)3,210,32624.00Part B - Other than Core Related Cost	22.00				0	22.00
24.00 Total Wage Related cost (Sum of Lines 1 -23) 3,210,326 Part B - Other than Core Related Cost 24.00					-	
Part B - Other than Core Related Cost					-	
					.,, =20	1
	25.00				74, 937	25.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-:	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0168	Peri od:	Worksheet S-3	
		From 01/01/2016	Part V	
		To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
Cost Center Description		Contract Labor		
		1.00	2.00	
PART V - Contract Labor and Benefit Cos	st			
Hospital and Hospital-Based Component	denti fi cati on:			
1.00 Total facility's contract labor and be	nefit cost	1, 335, 846	3, 210, 326	1.00
2.00 Hospi tal		1, 335, 846	3, 210, 326	2.00
3.00 Subprovider - IPF		0	0	3.00
4.00 Subprovider – IRF		0	0	4.00
5.00 Subprovider - (Other)		0	0	5.00
6.00 Swing Beds - SNF		0	0	6.00
7.00 Swing Beds - NF		0	0	7.00
8.00 Hospital-Based SNF		0	0	0.00
9.00 Hospital-Based NF		0	0	1.00
10.00 Hospital-Based OLTC				10.00
11.00 Hospital-Based HHA		0	0	11.00
12.00 Separately Certified ASC		0	0	
13.00 Hospital-Based Hospice		0	0	
14.00 Hospital-Based Health Clinic RHC		0	0	14.00
15.00 Hospital-Based Health Clinic FQHC		0	0	
16.00 Hospital-Based-CMHC		0	0	
16.10 Hospital-Based-CMHC 10		0	0	
17.00 Renal Dialysis		0	0	
18.00 0ther		0	0	18.00

Heal th	Financial Systems	LUTHERAN MUSCULOSKEL	ETAL CENTER		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC		Peri od:	Worksheet S-1	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
	L					1.00	
	Uncompensated and indigent care cost compu						
1.00	Cost to charge ratio (Worksheet C, Part I	line 202 column 3 di	vided by lin	ne 202 column	8)	0. 108061	1.00
0.00	Medicaid (see instructions for each line)					0 (00 110	0.00
2.00	Net revenue from Medicaid	nto from Madiaaida				3, 603, 412	2.00
3.00 4.00	Did you receive DSH or supplemental payment If line 3 is "yes", does line 2 include a		novmonte t	From Modicaid	2	Ν	3.00 4.00
4.00 5.00	If line 4 is "no", then enter DSH or supp				1	0	4.00 5.00
6.00	Medi cai d charges	rementar payments from				26, 705, 322	6.00
7.00	Medicaid cost (line 1 times line 6)					2, 885, 804	7.00
8.00	Difference between net revenue and costs	for Medicaid program	(line 7 minu	us sum of lin	es 2 and 5: if	2,000,001	8.00
	< zero then enter zero)	1 3					
	Children's Health Insurance Program (CHIP)) (see instructions fo	or each line	e)			
9.00	Net revenue from stand-alone CHIP					0	9.00
10.00	Stand-alone CHIP charges					0	10.00
	Stand-alone CHIP cost (line 1 times line					0	11.00
12.00	Difference between net revenue and costs	for stand-alone CHIP	(line 11 mir	nus line 9; i	f < zero then	0	12.00
	enter zero)	and program (and inc	tructions fo	vr acch line)			
13.00	Other state or local government indigent of Net revenue from state or local indigent				\	11, 289	12 00
14.00	Charges for patients covered under state					95, 198	
14.00	10)	of rocal rhurgent car		lot merudeu	11 111111111111111111111111111111111111	95, 190	14.00
15.00	State or local indigent care program cost	(line 1 times line 1	4)			10, 287	15.00
	Difference between net revenue and costs			program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)		3				
	Uncompensated care (see instructions for e						
	Private grants, donations, or endowment i		5	2			17.00
	Government grants, appropriations or trans					0	18.00
19.00	Total unreimbursed cost for Medicaid, CH	IP and state and loca	indigent o	care programs	(sum of lines	0	19.00
	8, 12 and 16)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col. 2)	
				1.00	2.00	3.00	
20.00	Charity care charges for the entire facil	ity (see instructions)	637, 50		637, 508	20.00
21.00	Cost of patients approved for charity car	e (line 1 times line 1	20)	68, 89	0 0	68, 890	21.00
22.00	Partial payment by patients approved for	charity care			0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 2	22)		68, 89	0 0	68, 890	23.00
						1.00	
24.00	Does the amount in line 20 column 2 inclu	de charges for notion	t dava hava	ad a longth a	F atau limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid o			id a rength o	Stay ITMIL	IN	24.00
25.00				ogram's Lengt	n of stav limit	0	25.00
27.00							
	Cost of non-Medicare and non-reimbursable				28)	67, 553	
	Cost of uncompensated care (line 23 colum					136, 443	30.00
31.00	Total unreimbursed and uncompensated care	cost (line 19 plus l	ne 30)			136, 443	31.00

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0168 P	Period: From 01/01/2016	Worksheet A	
					o 12/31/2016	Date/Time Pre 5/31/2017 9:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		65, 309	65, 309	3, 944, 245	4, 009, 554	1.00
2.00	00200 CAP REL COSTS-BEDG & TTAT		1, 228, 261			2, 093, 289	2.00
3.00	00300 OTHER CAP REL COSTS		0	100.000	0 1 000 077	0	3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 2, 551, 264	122, 288 34, 248, 712			2, 052, 565 31, 008, 920	4.00 5.00
7.00	00700 OPERATION OF PLANT	46, 478	1,006,808	1, 053, 286	-847	1, 052, 439	7.00
B. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	101, 074			101,074	
9.00 10.00	01000 DI ETARY	0	377, 320 339, 160			377, 320 338, 900	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	207, 114	430, 543			912, 706	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	401, 439 288	17, 010, 125 2, 106, 951			1, 588, 423 591, 292	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	663, 865			659, 563	
17.00	01700 SOCIAL SERVICE	0	41, 831	41, 831	0	41, 831	17.00
18.00 19.00	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	18.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0	C C	0	0	20.00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	C	0	0	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0	0			0	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		, 0	0	25.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 043, 603	432, 314			2, 475, 917	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	C	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	C	0	0	40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0			0	41.00 43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	C C	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	C	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1 (0 0	0	46.00
50.00	05000 OPERATING ROOM	3, 671, 379	5, 262, 781	8, 934, 160	684, 927	9, 619, 087	50.00
51.00	05100 RECOVERY ROOM	1, 265, 364	369, 583	1, 634, 947	-1, 634, 947	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 45, 606	45, 606	0 0 -45,606	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	108, 043	313, 753			342, 628	
54.01	03630 ULTRA SOUND	0	3, 963			3, 963	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 103	-	-	0 1, 403	
57.00	05700 CT SCAN	0	3, 960			3, 960	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	47, 935	18, 027	65, 962	0	65, 962	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 4, 069	0 424, 997	429, 066	0 0 -84,670	0 344, 396	59.00 60.00
50. 00 50. 01	06001 BLOOD LABORATORY	4,007	424, 997	429,000	0 0	0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	c	0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	62.00 63.00
53.00 54.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	16, 309			16, 309	65.00
66.00	06600 PHYSICAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 876, 364	699, 727			2, 277, 664	
67.00 68.00	06800 SPEECH PATHOLOGY	138, 520 119	10, 386 8			0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	158	20, 437			20, 595	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		761, 203 15, 035, 297	761, 203 15, 035, 297	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 447, 348	1, 447, 348	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	C	0 0	0	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0	0		0	0	90.00 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		, 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS	^		1			
94.00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94.00

Health Financial Systems LU	THERAN MUSCULOSKI	ELETAL CENTER	2	In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0168	Period: From 01/01/2016	Worksheet A	
				To 12/31/2016		
					5/31/2017 9:4	<u>1 am</u>
Cost Center Description	Sal ari es	Other		1 Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	2.00	2.00	4.00	<u>col.4)</u> 5.00	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	1.00	2.00	3.00	4.00	5.00	96.00
	0	0		0 0	° °	
	0	0		0 0	0	97.00 98.00
98. 00 09850 OTHER REIMBURSABLE COSTS 99. 00 09900 CMHC	0	0		0 0	0	98.00 99.00
	0	0		0 0	0	99.00
	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100. 00 101. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	0		0 0	0	101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	[0 0	0	105.00
106. 00 10600 HEART ACQUISTITION	0	0		0 0		105.00
107. 0010700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				109.00
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114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 363, 437	65, 364, 201	77, 727, 6	38 -484,030	77, 243, 608	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	853	21, 692	22, 5	45 1, 598	24, 143	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 MARKETI NG	1, 085, 087	426, 143	1, 511, 2	30 482, 432	1, 993, 662	194.00
194. 01 07951 SENI OR CI RCLE	0	2, 241	2, 2	41 0		194.01
200.00 TOTAL (SUM OF LINES 118-199)	13, 449, 377	65, 814, 277	79, 263, 6	54 0	79, 263, 654	200. 00

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64 00 6600 RADI OI SOTOPE 0 1, 403 67,00 05700 CT SCAN 0 3, 960 87,00 05900 CARDI AC CATHETRI ZATI ON 0 65, 962 97,00 05900 CARDI AC CATHETRI ZATI ON 0 0 90,00 06000 LABORATORY 0 344, 396 90,01 06000 LABORATORY 0 0 90,01 06000 MARCHETIC RESONANCE TRED BLOOD CELLS 0 0 90,0200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 90,0200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 90,0200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 90,00 05000 ITRAYENDUS THERAPY 0 1, 403 0 90,00 06000 PISTI CAL THERAPY 0 2, 277, 664 0 90,00 06000 CELCTROARDI OLOGY 20, 595 0 0 0 90,00 0000 CHARE			C			54
77. 00 05700 CT SCAN 0 3. 960 88. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 65, 962 90. 00 05900 CARDIAC CATHETERIZATION 0 0 90. 00 05001 LABORATORY 0 344, 396 90. 01 06001 LABORATORY 0 0 90. 01 06001 LABORATORY 0 0 91. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 92. 00 06400 INTRAVENOUS THERAPY 0 16, 309 94. 00 06400 INTRAVENOUS THERAPY 0 16, 309 95. 00 06300 RESPI RATORY THERAPY 0 2, 277, 664 96. 00 06400 PHYSI CAL THERAPY 0 0 98. 00 06800 SPECH PATHOLOGY 0 0 99. 00 06900 ELECTROCARDI 0LOGY 0 0 90. 00 06900 ELECTROCARDI 0LOGY 0 0 91. 00 07000 RELCTROCARDI 0LOGY 0 0 92.00			-			55
88 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 65,962 99 00 05900 CARDI AC CATHETERI ZATI ON 0 0 90 01 06000 LABORATORY 0 344, 396 90 01 06000 LABORATORY 0 0 91 00 06100 PBP CLI NI CAL LAB SERVICES-PRGM ONLY 0 0 92 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 93 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 94 00 06400 INTRAVENOUS THERAPY 0 16, 309 95 00 06600 PHYSI CAL THERAPY 0 22, 277, 664 97 00 06600 SPEECH PATHOLOGY 0 0 98 00 06800 SPEECH PATHOLOGY 0 0 99 00 0ELECTROCARDI OLOGRAPHY 0 0 0 910 00 07000 IELECTROCARDE TO PATI ENTS 0 1, 447, 348 94 00 07400 RENAE DA TI ENTS 0 0			-			56
99.00 05900 CARDI AC CATHETERI ZATI ON 0 90.00 06000 LABORATORY 0 91.00 06000 BLODD LABORATORY 0 91.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 92.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 93.00 06300 BLOOD TRAVENOUS THERAPY 0 0 94.00 06400 INTRAVENOUS THERAPY 0 0 96.00 06500 RESPI RATORY THERAPY 0 16, 309 96.00 06600 PHYSI CAL THERAPY 0 0 96.00 06600 SPEECH PATHOLOGY 0 0 97.00 06700 OCCUPATI ONAL THERAPY 0 0 98.00 66800 SPEECH PATHOLOGY 0 0 97.00 0000 SPEECH PATHOLOGY 0 0 97.00 MEL DEV. CHARGED TO PATI ENTS 761, 203 1 97.00 NURDL DEV. CHARGED TO PATI ENTS 1, 447, 348 1						57
00.00 06000 LABORATORY 0 344, 396 00.01 06001 BLOOD LABORATORY 0 0 1.00 06100 PBP CLINI CAL LAB SERVICES-PRGM ONLY 0 0 2.00 06300 BLOOD & PACKED RED BLOOD CELLS 0 0 3.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 4.00 06400 INTRAVENOUS THERAPY 0 16, 309 5.00 06500 RESPIRATORY THERAPY 0 2, 277, 664 7.00 06700 0CCUPATIONAL THERAPY 0 0 6.00 06600 PEECH PATHOLOGY 0 0 8.00 06800 SPEECH PATHOLOGY 0 0 9.00 06900 ELECTROCARDIOLOGY 0 0 0 10.00 07000 ELECTROCARDEPHALOGRAPHY 0 0 10.00 07000 ELECTROCARDEPHALOGRAPHY 0 0 10.00 07000 RELANCEPHALOGRAPHY 0 0			-			58
50.01 06001 BLOOD LABORATORY 0 0 50.01 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 0 52.00 062000 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 53.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 54.00 06400 INTRAVENUS THERAPY 0 16, 309 56.00 06600 PHYSI CAL THERAPY 0 0 56.00 06700 0CUPATI ONAL THERAPY 0 0 56.00 06700 CUEVPATI ONAL THERAPY 0 0 56.00 06600 SPEECH PATHORY THERAPY 0 0 56.00 06600 SPEECH PATHOLOGY 0 0 50.00 05000 SPEECH PATHOLOGY 0 0 50.00 07000 ELECTROCARDI OLOGY 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 035, 297 <						60
11.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 00 06400 INTRAVENOUS THERAPY 0 064.00 O6400 INTRAVENOUS THERAPY 0 065.00 06500 PESPI RATORY THERAPY 0 0 06400 OCCUPATIONAL THERAPY 0 0 06400 OCCUPATIONAL THERAPY 0 0 08.00 OCOV OCCUPATIONAL THERAPY 0 0 08.00 OBCOV ELECTROCARDIOLOGY 0 0 0 09.00 OGYOOV ELECTROENCEPHALOGRAPHY 0 0 0 10.00 OTOOV ELECTROENCEPHALOGRAPHY 0 0 0 10.00 OTOOV ELECTROENCEPHALOGRAPHY 0 0 0 10.00 OTOOV IMPL. DEV. CHARGED TO PATI ENTS 0 15, 035, 297 0 13.00 OTAVO RENAL DI ALYSIS 0 0 0 0 14.00 ORAGO FEDERALL VOLALI FIE PART 0 0 0 15.00 OSCOO IMPL DEV. CHARGED TO PATI ENTS 0 0				0		60
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0.3.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.4000 INTRAVENUUS THERAPY 0 0 0.55.00 06500 RESPI RATORY THERAPY 0 16, 309 0.600 06600 PHYSI CAL THERAPY 0 2, 277, 664 0.700 06700 OCCUPATI ONAL THERAPY 0 0 0.800 SPEECH PATHOLOGY 0 0 0 0.900 ELECTROCARDI OLOGY 0 0 0 0.900 ORGONO ELECTROCARDI OLOGY 0 0 0 1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 761, 203 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 1, 447, 348 74.00 RENAL DI ALYSI S 0 0 0 0000 REVAL HEALTH CLINIC 0 0 0 00000 RURAL HEALTH CLINIC 0 0 0 000000 G8900 </td <td></td> <td></td> <td></td> <td>o o</td> <td></td> <td>61</td>				o o		61
64.00 06400 INTRAVENOUS THERAPY 0 0 55.00 06500 RESPI RATORY THERAPY 0 16,309 65.00 06600 PHYSI CAL THERAPY 0 2,277,664 67.00 06700 0CCUPATI ONAL THERAPY 0 0 68.00 06600 SPEECH PATHOLOGY 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 15,035,297 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 1,447,348 74.00 OR400 REMAL DI ALYSI S 0 0 0 07400 REMAL DI ALYSI S 0 0 0 07500 ASC (NON-DI STINCT PART) 0 0 0 07400 REMAL DI ALYSI S 0 0 0 0800 FEDERALLY QUALI FIED HEALTH CENTER 0 0 39.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0				o		62
55.00 06500 RESPI RATORY THERAPY 0 16, 309 66.00 06600 PHYSI CAL THERAPY 0 2, 277, 664 67.00 06700 OCCUPATI ONAL THERAPY 0 0 88.00 06800 SPEECH PATHOLOGY 0 0 69.00 06900 ELECTROENCEPHALOGRAPHY 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 761, 203 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 035, 297 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 74.00 07400 RENAL DI ALYSI S 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 88.00 08800 RURAL HEALTH CLI NI C 0 0 0 99.00 09000 CLI NI C 0 0 0 0 90.00 09000 CLI NI C 0 0 0 0 90.00 09100 EMERGENCY 0 0 0	53.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0		63
b6.00 06600 PHYSI CAL THERAPY 0 2, 277, 664 b7.00 0C000 OCCUPATI ONAL THERAPY 0 0 b8.00 06800 SPECH PATHOLOGY 0 0 b9.00 06900 ELECTROCARDI OLOGY 0 0 b9.00 06900 ELECTROCARDI OLOGY 0 0 b7.00 07000 ELECTROENCEPHALOGRAPHY 0 0 b7.100 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 761, 203 b7.000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 035, 297 b7.000 07400 RENAL DI ALYSI S 0 1, 447, 348 b7.000 O7500 JASC (NON-DI STI NCT PART) 0 0 b0.00 0800 RURAL HEALTH CLINIC 0 0 b0.00 08000 FEDERALLY QUALI FIED HEALTH CENTER 0 0 b1.00 09000 CLINIC 0 0 0 b1.00 09000 CUN-DI STI NCT PART) 0 0 0 b1.00 09000 CUN-DI STI NCT PART) 0	4.00	06400 INTRAVENOUS THERAPY	C	0		64
57.00 06700 0CCUPATIONAL THERAPY 0 0 68.00 06800 SPECH PATHOLOGY 0 0 69.00 06900 ELECTROCARDIOLOGY 0 20,595 01.00 07000 ELECTROENCEPHALOGRAPHY 0 0 01.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 761,203 12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15,035,297 13.00 07300 DRUGS CHARGED TO PATIENTS 0 1,447,348 14.00 07400 RENAL DI ALYSI S 0 0 15.00 07500 ASC (NON-DI STINCT PART) 0 0 00 00 0 0 0 0 01TPATIENT SERVICE COST CENTERS 0 0 0 100 0800 RURAL HEALTH CLINIC 0 0 0 101 0 0 0 0 0 0 101.00 09000 CLINIC 0 0 0 0 101.00 09100 EMERGENCY 0 0 0 0 <td>5. 00</td> <td>06500 RESPI RATORY THERAPY</td> <td>C</td> <td>16, 309</td> <td></td> <td>65</td>	5. 00	06500 RESPI RATORY THERAPY	C	16, 309		65
98.00 06800 SPEECH PATHOLOGY 0 0 99.00 06900 ELECTROCARDIOLOGY 0 20, 595 00.00 07000 ELECTROENCEPHALOGRAPHY 0 0 11.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 761, 203 12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15, 035, 297 13.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 447, 348 14.00 07400 RENAL DI ALYSI S 0 0 15.00 07500 ASC (NON-DI STINCT PART) 0 0 00000 OTTON EDERALLY QUALIFIED HEALTH CENTER 0 0 00000 09000 CLINIC 0 0 01000 09000 DERGENCY 0 0 01000 09000 DESERVATION BEDS (NON-DI STINCT PART) 0 0 01000 09100 EMERGENCY 0 0 0 021.00 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 0 071.00 09100 EMERGENCY 0 0 0 <			C	2, 277, 664		66
99.00 06900 ELECTROCARDIOLOGY 0 20,595 10.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 11.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 761,203 760,203 12.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15,035,297 13.00 07400 RENAL DI ALYSI S 0 1,447,348 14.00 07500 ASC (NON-DI STI NCT PART) 0 0 00 07500 ASC (NON-DI STI NCT PART) 0 0 00 07500 ASC (NON-DI STI NCT PART) 0 0 00 0800 RURAL HEALTH CLINIC 0 0 00 0800 RURAL HEALTH CENTER 0 0 00 09000 CLINIC 0 0 0 01.00 09100 EMERGENCY 0 0 0 01.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 020.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0			C	0		67
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 761, 203 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 15, 035, 297 73.00 DRUGS CHARGED TO PATI ENTS 0 1, 447, 348 74.00 O7400 RENAL DI ALYSI S 0 0 75.00 OSCO ISINCT PART) 0 0 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 70.00 RENAL HEALTH CLINIC 0 0 70.00 O9000 CLINIC 0 0 70.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 70.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0			C			68
11.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 761, 203 12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15, 035, 297 13.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 447, 348 14.00 07400 RENAL DI ALYSI S 0 0 075.00 ASC (NON-DI STINCT PART) 0 0 0UTPATIENT SERVICE COST CENTERS 0 0 08800 RURAL HEALTH CLINIC 0 0 0900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0900 CLINIC 0 0 09100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 07100 OP100 EMERGENCY 0 0 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 017100 OP100 EMEGENCY 0 0 07100 OP2000 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 07100 OP3000 HOME PROGRAM DI ALYSIS 0 0 07100 <				20, 595		69
12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 15,035,297 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1,447,348 74.00 07400 RENAL DIALYSIS 0 0 075.00 ASC (NON-DISTINCT PART) 0 0 0 0UTPATIENT SERVICE COST CENTERS 0 0 0 08800 RURAL HEALTH CLINIC 0 0 09000 CLINIC 0 0 0 09000 CLINIC 0 0 0 09100 BERGENCY 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0100 MBURSABLE COST CENTERS 0 0 0 02.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 00 09200 MBURSABLE COST CENTERS 0 0 0 04.00 09400 HOME PROG						70
33.00 07300 DRUGS CHARGED TO PATIENTS 0 1,447,348 44.00 07400 RENAL DI ALYSI S 0 0 00 07500 ASC (NON-DI STINCT PART) 0 0 00 000 000 000 0 000 000 RURAL HEALTH CLINIC 0 0 000 08900 RURAL HEALTH CLINIC 0 0 000 09000 CLINIC 0 0 000 09000 CLINIC 0 0 000 09100 EMERGENCY 0 0 0000 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 01000 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 01000 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 011000 09100 EMERGENCY 0 0 0 02000 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 0 011000 OP400 HOME PROGRAM DI ALYSI S 0 0 0 05:00 O						71
44.00 07400 RENAL DI ALYSI S 0 0 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 000 08800 RURAL HEALTH CLINIC 0 0 0900 CLINIC 0 0 0 0000 09000 CLINIC 0 0 0000 09000 CLINIC 0 0 0000 09000 CLINIC 0 0 00000 CLINIC 0 0 0 01000 EMERGENCY 0 0 0 02000 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 0 01000 MBURSABLE COST CENTERS 0 0 0 02000 0BSERVATION BEDS (NON-DI STINCT PART) 0 0 0 01000 MBURSABLE COST CENTERS 0 0 0 02100 OSCRAM DI ALYSI S 0 0 0 0400 HOME PROGRAM DI ALYSI S 0 0 0 05.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>72</td></t<>						72
5.00 07500 ASC (NON-DI STINCT PART) 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 8.00 08800 RURAL HEALTH CLINIC 0 0 9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 09000 CLINIC 0 0 0.00 09000 CLINIC 0 0 1.00 09100 EMERGENCY 0 0 2.00 09SERVATION BEDS (NON-DISTINCT PART) 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 4.00 09400 HOME PROGRAM DI ALYSI S 0 0 5.00 09500 AMBULANCE SERVICES 0 0 6.00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0			-	.,		74
OUTPATI ENT SERVICE COST CENTERS 8.00 08800 RURAL HEALTH CLINIC 0 0 9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 09000 CLINIC 0 0 0.00 09000 CLINIC 0 0 0.00 09100 EMERGENCY 0 0 2.00 09SERVATION BEDS (NON-DISTINCT PART) 0 0 0THER REI MBURSABLE COST CENTERS 0 0 4.00 09400 HOME PROGRAM DI ALYSI S 0 0 5.00 09500 AMBULANCE SERVICES 0 0 6.00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0						75
8.00 08800 RURAL HEALTH CLINIC 0 0 9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 09000 CLINIC 0 0 1.00 09100 EMERGENCY 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 09400 HOME PROGRAM DIALYSIS 0 0 5.00 09500 AMBULANCE SERVICES 0 0 6.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0	2.00					
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 09000 CLINIC 0 0 1.00 09100 EMERGENCY 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 09400 HOME PROGRAM DI ALYSIS 0 0 5.00 09500 AMBULANCE SERVICES 0 0 6.00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0	8.00		C	0		88
0.00 09000 CLINIC 0 0 0.100 09100 EMERGENCY 0 0 0.200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0THER REIMBURSABLE COST CENTERS 0 0 04.00 09400 HOME PROGRAM DIALYSIS 0 0 05.00 09500 AMBULANCE SERVICES 0 0 06.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0				o o		89
01.00 09100 EMERGENCY 0 0 020.00 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0THER REI MBURSABLE COST CENTERS 0 0 04.00 09400 HOME PROGRAM DI ALYSIS 0 0 05.00 09500 AMBULANCE SERVICES 0 0 06.00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0				o		90
OTHER REI MBURSABLE COST CENTERS 04.00 09400 HOME PROGRAM DI ALYSI S 0 0 05.00 09500 AMBULANCE SERVI CES 0 0 06.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0			C	o		91
00 09400 HOME PROGRAM DI ALYSI S 0 0 05.00 09500 AMBULANCE SERVI CES 0 0 0 06.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0	2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
0.00 09500 AMBULANCE SERVICES 0 0 06.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0				1		
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0			-			94
						95
			-			96
		109700 DURABLE MEDICAL EQUIP-SOLD	1 C	기 ⁽⁾		97

LUTHERAN MUSCULOSKELETAL CENTER

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems LL	JTHERAN MUSCULOS	KELETAL CENTER		In Lieu	u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CC	N: 15-0168	Peri od:	Worksheet A	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pr 5/31/2017 9:	
Cost Center Description	Adjustments	Net Expenses		- · · · ·	0/01/2011/11	
	(See A-8) F	or Allocation				
	6.00	7.00				
98.00 09850 OTHER REIMBURSABLE COSTS	0	0				98.00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.0010100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0				105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUISITION	0	0				108.00
109.00 10900 PANCREAS ACQUISITION	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE	0	0				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-24,012,412	53, 231, 196				118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	24, 143				192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
194. 00 07950 MARKETI NG	0	1, 993, 662				194.00
194. 01 07951 SENI OR CI RCLE	-9, 676	-7,435				194.01
200.00 TOTAL (SUM OF LINES 118-199)	-24, 022, 088	55, 241, 566				200.00

	Financial Systems SIFICATIONS	LU	THERAN MUSCULOS		к CN: 15-0168	Peri od:	u of Form CMS-2552- Worksheet A-6
OLAS						From 01/01/2016 To 12/31/2016	
						10 12/31/2010	5/31/2017 9:41 am
		Increases		0.11			
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00			
	A - EMPLOYEE BENEFITS	3.00	4.00	5.00			
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 930, 277			1.0
	TOTALS		— — — •	1, 930, 277			
	B - OXYGEN COSTS	I	· ·	,			
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	45, 719			1. (
	PATI ENTS						
00		0.00	0	0			2.0
	TOTALS		0	45, 719			
~	C - RENTAL AND LEASE	1 00		2 522 025			1.0
00 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0	3, 523, 925 858, 973			1.0
00	PHYSICIANS' PRIVATE OFFICES	192.00	0	050, 973 1, 598			3. 0
00	PHISICIANS PRIVATE OFFICES	0.00	0	1, 598			4. 0
00		0.00	0	0			5.0
00		0.00	0	0			6.0
00		0.00	0	0			7. (
00		0.00	0	0			8. (
00		0.00	0	0			9. (
00		0.00	0	0			10. (
00		0.00	0	0			11. (
	TOTALS		0	4, 384, 496			
	D - OTHER CAPITAL COST						
00	CAP REL COSTS-BLDG & FIXT	1.00	0	62, 486			1. (
00	CAP REL COSTS-BLDG & FIXT	1.00	0	357, 834			2.0
00	CAP_REL_COSTS-MVBLE_EQUIP		0	<u>6, 055</u> 426, 375			3. (
	F - MARKETING		U	420, 375			
00	MARKETING	194.00	103, 932	619, 486			1. (
	TOTALS		103, 932	619, 486			
	G - CHIEF NURSING OFFICER	I					
00	NURSING ADMINISTRATION	13.00	192, 560	82, 529			1. (
	TOTALS		192, 560	82, 529			
	H - MEDICAL SUPPLIES						
00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	698, 594			1. (
0	PATIENTS	70.00	~	15 005 007			
00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15, 035, 297			2. (
00	MEDICAL SUPPLIES CHARGED TO	71.00	о	16, 890			3. (
0	PATIENTS	71.00	0	10, 070			5.0
00	OPERATING ROOM	50.00	0	110, 603			4.0
	TOTALS		0	15, 861, 384			
	I - DRUGS/IV SOLUTIONS						
00	DRUGS_CHARGED_TO_PATIENTS	73.00	0	1, 447, 348			1. (
	TOTALS		0	1, 447, 348			
	J - MISC DEPTS		F				
00	PHYSI CAL THERAPY	66.00	138, 639	10, 394			1. (
00				0			2.0
	TOTALS		138, 639	10, 394			
0	K - OTHER	EQ OOL	1 3/5 3/4	240 502			1 /
00	OPERATING ROOM	<u>50.</u> 00	<u>1, 265, 364</u> <u>1, 265, 364</u>	<u> </u>			1. (
	IVIALO		1, 700, 495	25, 177, 591			500.0

CLAS	SI FI CATI ONS			Provi der	CCN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Worksheet A-6 Date/Time Prepar 5/31/2017 9:41 a
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	₽.	
	6. 00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 930, 277	7	0	
	TOTALS	T		1,930,277	/	1	
	B - OXYGEN COSTS	·				·	
00	ANESTHESI OLOGY	53.00	0	45, 606		0	
00	CENTRAL SERVICES & SUPPLY	14.00	0	113		0	
	TOTALS			45, 719		-	
	C - RENTAL AND LEASE			10,717			
00	OPERATING ROOM	50.00	0	1,060,623	3	9	
00	PHARMACY	15.00	o	68, 599		9	
00	CENTRAL SERVICES & SUPPLY	14.00	0	46, 314		0	
00	RADI OLOGY-DI AGNOSTI C	54.00	0	79, 168		0	
	PHYSICAL THERAPY		0			0	
00		66.00		447, 460			Ę
00	OPERATION OF PLANT	7.00	0	847		0	6
00	NURSI NG ADMI NI STRATI ON	13.00	0	40		0	
00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 435, 897		0	8
00	MEDICAL RECORDS & LIBRARY	16.00	0	4, 302		0	C C
. 00	DI ETARY	10.00	0	260		0	1(
. 00	MARKETING	194.00	0	240, 986		Q	1
	TOTALS		o	4, 384, 496	b		
	D - OTHER CAPITAL COST						
00	ADMI NI STRATI VE & GENERAL	5.00	0	426, 375	5 1	12	
00		0.00	0	C) 1	13	
00		0.00	0	C) 1	12	
	TOTALS	T	<u> </u>	426, 375		7	
	F - MARKETING	· · · · · ·					
00	ADMI NI STRATI VE & GENERAL	5.00	103, 932	619, 486	b	0	
	TOTALS	+	103, 932	619, 486		1	
	G - CHIEF NURSING OFFICER	· · · · ·			4		
00	ADMI NI STRATI VE & GENERAL	5.00	192, 560	82, 529)	0	
00	TOTALS		192, 560	<u>82, 529</u>		1	
	H - MEDICAL SUPPLIES		172,000	02,02,			
00	CENTRAL SERVICES & SUPPLY	14.00	0	15, 776, 714	l	0	
00	LABORATORY	60.00	o	84, 670		0	
00		0.00	0	(0	
00		0.00	0			0	
00	TOTALS			15, 861, 384	· · · · · · · · · · · · · · · · · · ·	4	
	I - DRUGS/IV SOLUTIONS		U	10,001,304	ł		
00	PHARMACY	15 00	0	1 447 240		0	
00		<u>15.00</u>	0	1, 447, 348		Ō	
	TOTALS		0	1, 447, 348			
	J - MISC DEPTS	·	100 5				
00	OCCUPATIONAL THERAPY	67.00	138, 520	10, 386		0	
00	SPEECH PATHOLOGY	<u></u>			3	0	
	TOTALS		138, 639	10, 394	l		
	K – OTHER						
00	RECOVERY ROOM	51.00	1, 265, 364	369, 583		0	
	TOTALS	†	1, 265, 364	369, 583	3	7	
	Grand Total: Decreases		1, 700, 495	25, 177, 591	1		500

500.00 Grand Total: Decreases

	2	THERAN MUSCULOS	KELETAL CENTER			In Lie	u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0168		/01/2016 /31/2016	Worksheet A-7 Part I Date/Time Pre 5/31/2017 9:4	pared:
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on	To	otal	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00	4	. 00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	26, 765	0		0	0	0	2.00
3.00	Buildings and Fixtures	2, 671, 370	835, 405		0	835, 405	0	3.00
4.00	Building Improvements	11, 159, 530	746, 339		0	746, 339	160	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	0	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)	14,059,746	1, 581, 744		0 1	, 581, 744	160	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	14, 059, 746	1, 581, 744		0 1	, 581, 744	160	10.00
	· · · ·	Ending Balance	Fully					
		Ŭ	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	26, 765	0					2.00
3.00	Buildings and Fixtures	3, 506, 775	0					3.00
4.00	Building Improvements	11, 905, 709	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	202, 081	0					7.00
8.00	Subtotal (sum of lines 1-7)	15, 641, 330	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	15, 641, 330	o					10.00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu of For						u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0168	Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	narod
					10 12/31/2010	5/31/2017 9:4	1 am
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
		0.00	10.00	11.00	instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	65, 309			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 228, 261	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 293, 570	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	65, 309				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 228, 261				2.00
3.00	Total (sum of lines 1-2)	0	1, 293, 570	1			3.00
		1					•

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0168 Period: From 01/01/2016 Tom 01/2017 9: 41 an 12/31/2019 Worksheet A-7 Part 111 Date/Time Prepared: 5/31/2017 9: 41 an S/31/2017 9: 41 an Cost Center Description COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description ALLOCATION OF OTHER CAPITAL Cost Center Description Insurance for Ratio (col. 1 - col. 2) Insurance for Ratio (col. 2 - col. 2) Insurance for Ratio (col. 5 - for col. 6 - for col. 5 - for col. 6 - for col. 7 - f	Heal th	Financial Systems LL	THERAN MUSCULO	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
Cost Center Description Gross Assets Capitalized Leases Gross Assets for Ratio (col. 1 - col. Ratio (see instructions) Insurance 1.00 2.00 3.00 4.00 5.00 2) 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 1,345,747 0 1,345,747 0.086038 0 1.00 2.00 CAP REL COSTS-WUBLE EQUIP 14,295,583 0 14,295,583 0.913962 0 2.00 3.00 Total (sum of lines 1-2) 15,641,330 0 15,641,330 1.000000 0 3.00 1.00 Cost Center Description Taxes Other cols. 5 Total (sum of cols. 5 Depreciation cols. 5 Lease 0 0 0 2.00 3.00 1.00 2.00 3.00 10.00 0 2.00 3.00 1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>RECON</td> <td>CILIATION OF CAPITAL COSTS CENTERS</td> <td></td> <td>Provider C</td> <td>F</td> <td>rom 01/01/2016</td> <td>Part III Date/Time Prep</td> <td>pared: 1 am</td>	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	rom 01/01/2016	Part III Date/Time Prep	pared: 1 am
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS instructions instructions 1.00 2.00 3.00 4.00 5.00 1.00 CAP REL COSTS-BLDG & FIXT 1, 345, 747 0 1, 345, 747 0.086038 0 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 14, 295, 583 0 14, 295, 583 0.913962 0 2.00 3.00 Total (sum of lines 1-2) 15, 641, 330 0 15, 641, 330 1.000000 0 3.00 Cost Center Description Taxes Other Capital -Relate d costs Total (sum of cols 5 d costs Depreciation Lease Lease SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description 0 0 0 9.00 10.00 Other Capital -Relate d costs Total (sum of through 7) 10.00 Other Capital -Relate d costs 0 0 0 0 0 2.00 Other Capital -Relate d Costs Center Description 0 0			COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,000 1,000 2.00 CAP REL COSTS-BLDG & FIXT 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,345,747 0 1,000 2.00 2.00 CAP REL COSTS-MUBLE EQUIP 1,4295,583 0 913962 0 2.00 2.00 1.00 1.00 2.00 1.00 1.00 2.00 1.641,330 1.00 2.00 1.00 1.00 1.00 2.00 1.641,330 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 2.00 0 0 0 0 1.00 1.00 2.00 0 0 0 0 2.00 1.00 2.00 0 0		Cost Center Description		Leases	for Ratio (col. 1 - col. 2)	instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 1,345,747 0 1,345,747 0.086038 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 14,295,583 0 14,295,583 0.913962 0 2.00 3.00 Total (sum of lines 1-2) 15,641,330 0 15,641,330 1.000000 0 3.00 Cost Center Description Taxes 0 ther Capital -Relate d Costs Total (sum of cols.5 through 7) Depreciation Lease 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 9.00 10.00 Cost Center Description Taxes 0 0 0 9.00 10.00 Cost Center Description Taxes 0 0 0 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.028,443 0 2.00 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.09,99,92 -10,460 2.00 SUMMARY OF CAPITAL Cost Center Description Interest				2.00	3.00	4.00	5.00	
2.00 CAP REL COSTS-MVBLE EQUIP 14,295,583 0 14,295,583 0.913962 0 2.00 3.00 Total (sum of lines 1-2) 15,641,330 0 15,641,330 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Total (sum of cols.5 Depreciation Lease 0 CAP REL COSTS-BUGB & FIXT 0 0 0 9.00 10.00 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 9.00 10.00 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.02 0 1.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00 1.00 3.00 Total (sum of lines 1-2) 0 0 0 2.00 2.00 2.038,443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 2.03 0 2.03 0 <t< td=""><td>4 00</td><td></td><td></td><td></td><td>4 945 745</td><td></td><td></td><td>1 00</td></t<>	4 00				4 945 745			1 00
3.00 Total (sum of lines 1-2) 15, 641, 330 0 15, 641, 330 1.000000 0 3.00 Cost Center Description ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 9ART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 6.00 7.00 8.00 9.00 10.00 0 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 0 0 0 2.00 2.03, 942 -10, 460 1.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Total (sum of lines 1-2) 0 0 0 2.00 2.03, 942 -10, 460 2.00 Center Description Interest Insurance (see instructions) Total (see instructions) Other instructions) Total (2) (sum of cols. 9 0 11.00 <								
PART 111 - RECONCILIATION OF CAPITAL OIL OCATION OF OTHER CAPITAL SUMMARY OF CAPITAL 1.00 CAP REL COSTS-BLDG & FIXT 0 0 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 9.00 10.00 3.00 Total (sum of lines 1-2) 0 0 0 9.00 10.00 Summary of Capital - Reconciliant - Reconciliant of capital - Reconciliant - Reconcilian								
Cost Center Description Taxes Other Capital-Relate d Costs Total (sum of cols. 5 through 7) Depreciation Lease 1.00 CAP REL COSTS-BLDG & FIXT 0 7.00 8.00 9.00 10.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 911,499 -10,460 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2.02 2.02 2.03 2.03 2.03 2.03 2.00 2.028,443 0 2.00 2.00 2.028,443 0 2.00 2.00 2.03 2.00 2.03 2.00 2.02 0 0 2.00 2.03 3.00 2.03 3.00 10.460 1.00 2.00 2.028,443 0 2.00 2.00 0 0 2.00 2.03 3.00 10.460 3.00 10.00 2.03,939,942 -10,460 3.00 Loss Center Description Interest Insurance (see instructions) Taxes (see instructions) Other instructions) Total (2) (sum of cols. 9 through 14) <td>3.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3.00</td>	3.00							3.00
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS Cost S Cost Center Description 0 0 0 0 911, 499 -10, 460 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.00 2, 028, 443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.00 2, 939, 942 -10, 460 3.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.00 2, 939, 942 -10, 460 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) Interest Insurance (see instructions) Taxes (see instructions) Total (2) (sum of cols. 9 through 14) Insurance instructions) Interest Instructions 11.00 12.00 13.00 14.00 15.00 CAP REL COSTS-BLDG & FIXT 0 62,486 357,834 0 1,321,359 1.00			ALLOCA			JUNIMART		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 9.00 10.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 911,499 -10,460 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 2,028,443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 2,939,942 -10,460 3.00 Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Of capital -Relate d Costs (see instructions) of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 62,486 357,834 0 1,321,359 1.00 CAP REL COSTS-BLDG & FIXT 0 6,055 0 0 1,321,359 1.00 CAP REL COSTS-MVBLE EQUIP 0 6,055 0 0 1,321,359 1.00 CAP REL COSTS-MVBLE EQUIP 0		Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
6.00 7.00 8.00 9.00 10.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 0 0 911,499 -10,460 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 2.00 2.028,443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2.939,942 -10,460 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 62,486 357,834 0 1,321,359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6,055 0 0 2,034,498 2.00		•		Capi tal -Rel ate	cols. 5			
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 911, 499 -10, 460 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00 2, 028, 443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2, 939, 942 -10, 460 3.00 SUMMARY OF CAPITAL Cost Center Description Total (sum of lines 1-2) Interest Insurance (see instructions) Taxes (see Other Capital -Relate of Costs (see instructions) Interest Insurance (see instructions) Total (2) (sum of costs (see instructions) 11.00 12.00 13.00 14.00 15.00 O 62, 486 357, 834 O 1, 321, 359 1.00 CAP REL COSTS-BLDG & FIXT 0 62, 486 357, 834 0 1, 321, 359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6, 055 0 0 2, 034, 498 2.00				d Costs	through 7)			
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 911, 499 -10, 460 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2,028, 443 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 2,939, 942 -10, 460 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate of cols. 9 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 62, 486 357, 834 0 1, 321, 359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6, 055 0 0 2, 034, 498 2.00				7.00	8.00	9.00	10.00	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 2.00 2.028,443 0 2.00 2.939,942 -10,460 3.00 SUMMARY OF CAPI TAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 0 62,486 357,834 357,834 0 1,321,359 2.00 1.00			ENTERS					
3.00 Total (sum of lines 1-2) 0 0 0 2,939,942 -10,460 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 2.00 0 62,486 357,834 0 1,321,359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6,055 0 0 2,034,498 2.00			0	0	0			
SUMMARY OF CAPITAL SUMMARY OF CAPITAL Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of cols. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 62,486 357,834 0 1,321,359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6,055 0 0 2,034,498 2.00			0	0	(
Cost Center Description Interest Insurance (see instructions) Taxes (see instructions) Other Capital -Relate d Costs (see instructions) Total (2) (sum of col s. 9 through 14) 11.00 12.00 13.00 14.00 15.00 PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS O 62,486 357,834 O 1,321,359 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 62,055 0 0 2,034,498 2.00	3.00	Total (sum of lines 1-2)	0	0	(-10, 460	3.00
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 62,486 357,834 0 1,321,359 1.00 CAP REL COSTS-BLDG & FIXT 0 62,055 0 0 2.00				SL	JMMARY OF CAPI	IAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS 0 62,486 357,834 0 1,321,359 1.00 CAP REL COSTS-BLDG & FIXT 0 62,055 0 0 2.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 62,486 357,834 0 1,321,359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 62,055 0 0 2,034,498 2.00		•						
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 0 62,486 357,834 0 1,321,359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6,055 0 0 2,034,498 2.00				,		d Costs (see	through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 62, 486 357, 834 0 1, 321, 359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6, 055 0 0 2, 034, 498 2.00						instructions)		
1.00 CAP REL COSTS-BLDG & FIXT 0 62, 486 357, 834 0 1, 321, 359 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 6, 055 0 0 2, 034, 498 2.00				12.00	13.00	14.00	15.00	
2. 00 CAP REL COSTS-MVBLE EQUI P 0 6, 055 0 0 2, 034, 498 2. 00			-	1		1		
			u u			0		
3.00 lotal (sum of lines 1-2) 0 68,541 357,834 0 3,355,857 3.00			0			0		
	3.00	Total (sum of lines 1-2)	0	68, 541	357,834	0	3, 355, 857	3.00

5051	MENTS TO EXPENSES			Provider CCN: 15-0168	Period: From 01/01/2016	Worksheet A-8	
					To 12/31/2016	Date/Time Prep 5/31/2017 9:4	
				Expense Classification of To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line #	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00	0	1. (
00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.
	discounts (chapter 8)		0				
00	Refunds and rebates of expenses (chapter 8)		U		0.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter 21)	A	-2, 968	ADMI NI STRATI VE & GENERAL	5.00	0	7.
00	Television and radio service (chapter 21)	A	-23, 443	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.
00 . 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 60, 008-		0.00	0 0	
. 00	Sale of scrap, waste, etc.		0		0.00	0	11.
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-2, 477, 535			О	12.
	Laundry and linen service Cafeteria-employees and guests		0		0.00		13. 14.
	Rental of quarters to employee		0		0.00	0	
. 00	and others Sale of medical and surgical supplies to other than patients		C		0.00	0	16.
. 00	Sale of drugs to other than		0		0.00	0	17.
. 00	patients Sale of medical records and		0		0.00	0	18.
. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.
	books, etc.)		-				
. 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0.00 0.00	0 0	
. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	О	22.
. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
. 00	Utilization review - physicians' compensation (chapter 21)		O	UTILIZATION REVIEW-SNF	114.00		25.
. 00	Depreciation - CAP REL	А	4, 270	CAP REL COSTS-BLDG & FIXT	1.00	9	26.
. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-160, 403	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29 30
. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
	instructions)						
	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.
. 00	CAH HIT Adjustment for Depreciation and Interest		0	1	0.00	0	32.
	RENTAL INCOME CABLE EXPENSE	B		CAP REL COSTS-BLDG & FIXT OPERATION OF PLANT	1.00 7.00		33. 33.

Health Financial Sv	rstems	1.07	THERAN MUSCULO	SKELETAL CENTER	Inlie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXP				Provi der CCN: 15-0168	Peri od:	Worksheet A-8	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
				Expense Classification of	n Worksheet A	575172017 7.4	
				To/From Which the Amount i			
					,		
0+ 0			A	Cast Castar	1: //		
COST C	enter Description	1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33.02		1.00	2.00	3.00	4.00		33.02
33.02			0		0.00		33.02
33.04			0		0.00		33.03
33.05			0		0.00		33.04
34.00 OTHER MISC F		В	97 011	ADMI NI STRATI VE & GENERAL	5.00		34.00
35.00 MARKETING EX		A		ADMINI STRATI VE & GENERAL	5.00		34.00
36.00 LOBBYING EX		A		ADMINISTRATIVE & GENERAL	5.00		36.00
37.00 PHYSICIAN R		A		ADMINISTRATIVE & GENERAL	5.00		37.00
38.00 LOBBYING EX		A		ADMINISTRATIVE & GENERAL	5.00		37.00
	CONTRI BUTI ONS	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00		39.00
40.00 HR - EVENT F		A		EMPLOYEE BENEFITS DEPARTME			40.00
40.00 PENALTIES	LANNING	A		ADMI NI STRATI VE & GENERAL	5.00		40.00
42.00 HOSP ADMIN-F		A		SENIOR CIRCLE	194.01		41.00
DUES/SUB	JIII J/ I KU	~	-9,070		194.01	0	42.00
43.00 MSHI PS/PROF	DUES/SUB	А	-4 127	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00 PHYSICIAN G		A		ADMI NI STRATI VE & GENERAL	5.00		44.00
45.00 MINORITY IN		A		ADMI NI STRATI VE & GENERAL	5.00		45.00
	of lines 1 thru 49)		-24, 022, 088		0.00		50.00

(Transfer to Worksheet A, column 6, line 200.)

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

Heal th	Financial Systems	LUTHERAN MUSCUL	OSKELETAL CENTER	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAIMED	
4 00	HOME OFFICE COSTS:			10.00/		1 00
1.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL - BLDG & FIXTUR		0	1.00
2.00		CAP REL COSTS-MVBLE EQUI P	PASI CAPITAL COSTS - MOVEABL		0	2.00
3.00		ADMINISTRATIVE & GENERAL	PASI OPERATING COST	438, 488	183, 415	
3.01		CAP REL COSTS-MVBLE EQUI P	NEW CAPITAL - MOVABLE EQ.	122, 168	0	3.01
3.02		ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1, 470, 526	1, 499, 235	
3.03		ADMINISTRATIVE & GENERAL	MALPRACTICE	118, 595	23, 411	3.03
3.04		CAP REL COSTS-BLDG & FIXT	FWO SUGERY CENTER	139, 881	535, 419	
3.05		CAP REL COSTS-BLDG & FIXT	FWO CAMPUS MRI	13, 028	63, 916	
3.06		CAP REL COSTS-BLDG & FIXT	FWO CAMPUS PT	84, 153	254, 765	
3.07		CAP REL COSTS-BLDG & FIXT	TOH RENT/LINEN	449, 526	110, 784	
3.08		ADMINISTRATIVE & GENERAL	TOH MGT FEES	96, 281	338, 414	3.08
3.09	1.00	CAP REL COSTS-BLDG & FIXT	TOH RENT/LUTHERAN	0	2, 430, 949	3.09
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	8, 844	0	4.00
5.00	TOTALS (sum of lines 1-4).			2, 962, 773	5, 440, 308	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of	1		
		Ownershi p		Ownershi p			
1.00	2.00	3.00	4.00	5.00			

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

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

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

Ternibur	Sement under titte Aviii.				
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 HOSPI TAL 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 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		LUTHERAN MUSCULOSKELETAL CENTER				u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVI	CES FROM RELATED C	ORGANIZATIONS A	AND HOME	Provider CCN: 15-0168	Period: From 01/01/2016	Worksheet A-8-1
						Date/Time Prepared:

								5/31/	<u>2017 9:41 am</u>	1
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED	AS A RESULT O	F TRANSA	CTIONS W	ITH RELATED (ORGANIZATIONS OR CLAIME) (
	HOME OFFICE CO									
1.00	18, 396								1.	. 00
2.00	2, 887	9							2.	. 00
3.00	255, 073	9							3.	. 00
3.01	122, 168	9							3.	. 01
3.02	-28, 709	9							3.	. 02
3.03	95, 184	9							3.	. 03
3.04	-395, 538	9							3.	. 04
3.05	-50, 888	9							3.	. 05
3.06	-170, 612	9							3.	. 06
3.07	338, 742	9							3.	. 07
3.08	-242, 133	9							3.	. 08
3.09	-2, 430, 949	9							3.	. 09
4.00	8, 844	9							4.	. 00
5.00	-2, 477, 535								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

1103 1101	been posted to worksheet A,		z, the amount	arrowabre	should be	i nui cateu	tin s part.	
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	6.00							
	B. INTERRELATIONSHIP TO RELA	FED 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 ceimbursement under title XVII

rerinbur	Sement under title AVIII.	
6.00	HEALTHCARE	6.00
7.00	HEALTHCARE	7.00
8.00	HEALTHCARE	8.00
9.00		9.00
10.00		10.00
100.00		100.00
(4) 11	المراجع والمراسية متراسية المكر مراف	

(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.

Heal th	Financial Syste	ems L	UTHERAN MUSCULO)SKELETAL CENTE	R	In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSICI	I AN ADJUSTMENT		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Date/Time Pre 5/31/2017 9:4	epared:
	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	5.00	ADMINISTRATIVE & GENERAL	72, 166	39, 824	32, 342	136, 700	185	1.00
2.00	0.00		0	0	C	0	0	2.00
3.00	0.00		0	0	C	0	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0, 00		0	0	C	0	0	5.00
6.00	0, 00		0	0	0	0	0	6.00
7.00	0.00		0	0	c C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C C	0	0	9.00
10.00	0.00		0	0		0	0	10.00
200.00	0.00		72, 166	39, 824	32, 342	0	-	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		32,342 Cost of	Provi der	Physician Cost	200.00
	WKSL A LINE #	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
		rdentriter	LI IIII L		Continuing	Share of col.	Insurance	
					Education	12	Thisurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	12, 158	9.00	12.00			1.00
	0.00	ADMINISTRATIVE & GENERAL			C		-	
2.00			0	0	C		-	2.00
3.00	0.00		0	0	(-	3.00
4.00	0.00		0	0	6	, s	0	4.00
5.00	0.00		0	0	C		, i i i i i i i i i i i i i i i i i i i	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	-	0	8.00
9.00	0. 00		0	0	C	-	0	9.00
10.00	0. 00		0	0	C	0	0	10.00
200.00			12, 158	608	C	-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0	12, 158	20, 184			1.00
2.00	0. 00		0	0	C			2.00
3.00	0. 00		0	0	C			3.00
4.00	0.00		0	0	C	-		4.00
5.00	0.00		0	0	C	0		5.00
6.00	0.00		0	0	C	0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0. 00		0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0.00		0	0	C	0		10.00
200.00			0	12, 158	20, 184	60,008		200.00
	. 1			,	.,			

COST A	Financial Systems LU LLOCATION - GENERAL SERVICE COSTS	JTHERAN MUSCULOS	Provider CC	CN: 15-0168 P	eriod: rom 01/01/2016	u of Form CMS-2 Worksheet B Part I	
				T	0 12/31/2016	Date/Time Pre 5/31/2017 9:4	pared: 1 am
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)					
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 321, 359	1, 321, 359				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 034, 498	1, 521, 557	2, 034, 498			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 045, 863	0	0	2, 045, 863		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 782, 994	40, 177	61, 860	342, 987	10, 228, 018	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 019, 641 101, 074	297, 493	458, 051 0	7, 070	1, 782, 255 101, 074	7.00 8.00
9.00	00900 HOUSEKEEPING	377, 320	0	0	0	377, 320	
	01000 DI ETARY	338, 900	0	0	0	338, 900	
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	912, 706 1, 588, 423	0 75, 283	0 115, 914	60, 797 61, 065	973, 503 1, 840, 685	13.00 14.00
	01500 PHARMACY	591, 292	0	0	44	591, 336	
	01600 MEDICAL RECORDS & LIBRARY	659, 563	0	0	0	659, 563	16.00
	01700 SOCIAL SERVICE	41, 831	0	0	0	41, 831	17.00
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18.00 19.00
	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	2, 475, 917	183, 079	281, 888	310, 865	3, 251, 749	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00 45.00
	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	9, 619, 087	402, 366	619, 521 173, 320	750, 954	11, 391, 928	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	112, 567 0	173, 320	0	285, 887 0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	342, 628	25, 788	39, 706	23, 727	431, 849	
	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	3, 963	0	0	0	3, 963 0	54.01 55.00
	05600 RADI OLOGI - ITILKAFLUTTO	1, 403	0	0	198	1,601	56.00
57.00	05700 CT SCAN	3, 960	0	0	0	3, 960	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	65, 962	0	0	0	65, 962	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 344, 396	0	0	0 619	0 345, 015	59.00 60.00
	06001 BLOOD LABORATORY	0	0	0	019	345, 015	60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
	06500 RESPIRATORY THERAPY	16, 309	0	0	0	16, 309	
	06600 PHYSI CAL THERAPY	2, 277, 664	184, 606	284, 238	306, 514	3, 053, 022	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY		0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	20, 595	0	0	24	20, 619 0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	761, 203	0	0	0	761, 203	
	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 035, 297	0	0	0	15, 035, 297	
	07300 DRUGS CHARGED TO PATIENTS	1, 447, 348	0	0	0	1, 447, 348	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00 75.00
	OUTPATIENT SERVICE COST CENTERS			0			
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
89. 00 90. 00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY	0	0	0	0	0 0 0	1

Health Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prep 5/31/2017 9:41	
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS	1					
94. 0009400HOMEPROGRAMDI ALYSI S95. 0009500AMBULANCESERVI CES96. 0009600DURABLEMEDI CALEQUI P-RENTED97. 0009700DURABLEMEDI CALEQUI P-SOLD	000000000000000000000000000000000000000	0			0 0 0	94.00 95.00 96.00 97.00
98. 00 09850 OTHER REI MBURSABLE COSTS	0				0	97.00 98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	-		-			
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106. 00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0		0 0		111.00 113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		114.00 115.00
116. 00 11600 HOSPI CE	0			0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	53, 231, 196	1, 321, 359	2, 034, 49	8 1, 864, 864	53, 050, 197	
NONREI MBURSABLE COST CENTERS	33,231,170	1, 521, 557	2,034,47	1,004,004	33, 030, 177	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	24, 143	0		0 130	24, 273	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194. 00 07950 MARKETI NG	1, 993, 662	0		0 180, 869	2, 174, 531	194.00
194. 01 07951 SENI OR CI RCLE	-7, 435	0		0 0	-7, 435	194.01
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	55, 241, 566	1, 321, 359	2, 034, 49	8 2, 045, 863	55, 241, 566	202.00

	Financial Systems L ALLOCATION - GENERAL SERVICE COSTS	UTHERAN MUSCULOS	Provider C	CN: 15-0168 F	Period: From 01/01/2016	eu of Form CMS-: Worksheet B Part I	2552-10
					o 12/31/2016		
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	10, 228, 018					5.00
7.00	00700 OPERATION OF PLANT	404, 898	2, 187, 153				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	22, 962	0	124, 036			8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	85, 721 76, 992	0			415, 892	9.00 10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0, 772	0			413, 072	
13.00	01300 NURSING ADMINISTRATION	221, 163	0	C	0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	418, 172	167, 386	C	35, 437		14.00
15.00	01500 PHARMACY	134, 341	0	0	0	-	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	149, 842 9, 503	0			0	16.00 17.00
18.00	01850 OTHER GENERAL SERVICES	9, 503	0			0	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	C	0 0	0	20.00
21.00	02100 I & SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0			0	22.00 23.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	0	L(<u> </u>	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	738, 742	407, 062	101, 980	86, 179	415, 892	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	C	0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33.00
40.00	04000 SUBPROVIDER - IPF	0	0			0	34.00 40.00
41.00	04100 SUBPROVIDER - IRF	0	0		0	0	41.00
43.00	04300 NURSERY	0	0	(C	0 0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0			0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	(<u> </u>	0	46.00
50.00	05000 OPERATING ROOM	2, 588, 052	894, 627	22, 056	189, 401	0	50.00
51.00	05100 RECOVERY ROOM	64, 949	250, 284	C	52, 988		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	-	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 98, 109	0 57, 338		0 0 12, 139	0	53.00 54.00
54.00	03630 ULTRA SOUND	900	0, 330		0 12, 137	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0 0	0	55.00
56.00	05600 RADI OI SOTOPE	364	0	C	0 0	0	56.00
57.00	05700 CT SCAN	900	0		0	0	
58.00 59.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	14, 985	0			0	
60.00	06000 LABORATORY	78, 382	0		0	0	
60.01	06001 BLOOD LABORATORY	0	0	C	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	1
63.00 64.00	06400 INTRAVENOUS THERAPY	0	0			0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	3, 705	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	693, 595	410, 456	C	86, 897	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	68.00 69.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 684	0			0	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	172, 932	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 415, 782	0	0	0	0	72.00
12.00		328, 813	0	(C	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0	(0 ס	0	74.00
73.00 74.00	07400 RENAL DI ALYSI S	0	~		<u> </u>		
73.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	(0	0	75.00
73.00 74.00	07400 RENAL DI ALYSI S	-	0		-	1	1
73.00 74.00 75.00 88.00 89.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER	-	0 0 0	-	-	1	88. 00 89. 00
73.00 74.00 75.00 88.00 89.00 90.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	-	0	-	-	000000000000000000000000000000000000000	88. 00 89. 00 90. 00
73.00 74.00 75.00 88.00 89.00 90.00 91.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	-	0 0 0 0 0 0 0	-	-	0	88.00 89.00 90.00 91.00
73.00 74.00 75.00 88.00 89.00 90.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-	0 0 0 0 0	-	-	000000000000000000000000000000000000000	88. 00 89. 00 90. 00
73.00 74.00 75.00 88.00 89.00 90.00 91.00 92.00 94.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	-		-		000000000000000000000000000000000000000	88.00 89.00 90.00 91.00 92.00 94.00
73.00 74.00 75.00 88.00 89.00 90.00 91.00 92.00 94.00 95.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	-				0 0 0 0	88. 00 89. 00 90. 00 91. 00 92. 00 94. 00 95. 00
73.00 74.00 75.00 88.00 89.00 90.00 91.00 92.00 94.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	-				0 0 0 0	88. 00 89. 00 90. 00 91. 00 92. 00 94. 00 95. 00 96. 00

Health Financial Systems Ll	SKELETAL CENTER	LETAL CENTER In Lie			u of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0168	Peri od:			
				From 01/01/2016	Part I		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4		
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
cost center bescription	& GENERAL	PLANT	LINEN SERVIC		DIETART		
	5.00	7.00	8.00	9,00	10,00		
99.00 09900 CMHC	0.00	0	0.00	0 0	0	99.00	
99. 10 09910 CORF	0	0		0 0	0		
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0 0	0	100.00	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00	
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00	
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00	
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00	
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00	
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0	0	110.00	
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00	
113.00 11300 INTEREST EXPENSE						113.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00	
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 728, 488	2, 187, 153	124, 03	463, 041	415, 892	118.00	
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00	
191. 00 19100 RESEARCH	0	0		0 0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 514	0		0 0		192.00	
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00	
194. 00 07950 MARKETI NG	494, 016	0		0 0		194.00	
194. 01 07951 SENI OR CI RCLE	0	0		0 0	0	194.01	
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)	10, 228, 018	2, 187, 153	124, 03	463, 041	415, 892	202.00	

	Financial Systems L NLOCATION - GENERAL SERVICE COSTS		SKELETAL CENTER Provider CC	N: 15-0168 Pe	eriod: Tom 01/01/2016	u of Form CMS-: Worksheet B Part I	
				To		Date/Time Pre 5/31/2017 9:4	
	Cost Center Description	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
		12.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	-	1				
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	(., . , . ,				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			2, 461, 680 11	725, 688		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			0	125,088	809, 405	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0 0	0	0	0	18.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD			0	0	0	20.00
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD			0	0	0	22.00
23.00	02300 PARAMED ED PRGM		0 0	0	0	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			00.000		10.0/2	1 20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			23, 928 0	0	18, 069 0	30.00 31.00
32.00	03200 CORONARY CARE UNI T			0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF			0	0	0	40.00
41.00	04300 NURSERY			0	0	0	41.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	(0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	(0	0	0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	844, 909	128, 309	0	341, 142	50.00
51.00	05100 RECOVERY ROOM			0	0	43, 531	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0 0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND			322 0	0	18, 426 212	1
55.00	05500 RADI OLOGY-THERAPEUTI C			0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	43	
	05700 CT SCAN	0	0	0	0	13	•
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI)			0	0	107 0	58.00 59.00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY			669	0	7, 896	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY			0	0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY			0	0	709	
66.00	06600 PHYSI CAL THERAPY	0	0	11, 116	0	23, 533	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0	0	0	0 696	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY			0	0	090	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			237, 765	0	42, 926	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1, 902, 832	0	251, 538	
73.00	07300 DRUGS CHARGED TO PATIENTS		0	156, 651	725, 688	60, 530	•
74.00 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)			0	0	34 0	74.00
	OUTPATIENT SERVICE COST CENTERS			0		0	1
88.00	08800 RURAL HEALTH CLINIC	(0 0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
90.00 91.00	09000 CLINIC 09100 EMERGENCY		0	0	0	0	90.00 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, 0	0	0	0	91.00
50	OTHER REIMBURSABLE COST CENTERS						1
	09400 HOME PROGRAM DI ALYSI S	(0	0	0	0	94.00
94.00				1	1		0-
94.00 95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 0	95.00 96.00

Health Financial Systems L	UTHERAN MUSCULOS	SKELETAL CENTER		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre	pared:
					5/31/2017 9:4	1 am
Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL	ADMI NI STRATI ON			RECORDS &	
			SUPPLY		LI BRARY	
	12.00	13.00	14.00	15.00	16.00	
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS		-		-	-	
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 194, 666	2, 461, 60	3 725, 688	809, 405	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	7	7 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194.00 07950 MARKETI NG	0	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0	0	194.01
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)	0	1, 194, 666	2, 461, 68	0 725, 688	809, 405	202.00

	Financial Systems LI ALLOCATION - GENERAL SERVICE COSTS	JTHERAN MUSCULUS	SKELETAL CENTER Provider C	CN: 15-0168 F	Period:	u of Form CMS-2 Worksheet B	2552-10
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	
			OTHER GENERAL			5/31/2017 9:4 INTERNS &	1 am
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCIAL SERVICE	S	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	
		17.00	18.00	19.00	20.00	21.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		[F	1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00 12.00	01000 DI ETARY 01200 MAI NTENANCE OF PERSONNEL						10.00 12.00
12.00	01300 NURSI NG ADMI NI STRATI ON						12.00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
	01700 SOCIAL SERVICE	51, 334					17.00
	01850 OTHER GENERAL SERVICES	0	0				18.00
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	C			19.00
20.00 21.00	02000 NURSTING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0			_	22.00
23.00	02300 PARAMED ED PRGM	0	0				23.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	51, 334	0	C) 0	0	30.00
	03100 I NTENSI VE CARE UNI T	0	0				31.00
	03200 CORONARY CARE UNI T	0	0	C	0 0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0			0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	C	0	0	41.00
43.00		0	0	0	0	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		-	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0				1
50.00	ANCI LLARY SERVI CE COST CENTERS		0			0	50.00
50.00 51.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	0			0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	0			0	54.00 54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
	05600 RADI OI SOTOPE	0	0	C	0 0	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0			0	59.00
	06000 LABORATORY	0	0	C	0 0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	C	0 0	0	60.01 61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0			0	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	(0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0			0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	0			0	73.00
	07500 ASC (NON-DISTINCT PART)	0	0			0	74.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	08800 RURAL HEALTH CLINIC	0	0	(0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0			0	89.00 90.00
	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.00							
	OTHER REIMBURSABLE COST CENTERS	0	0	() (0	94.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				94.00 95.00 96.00

Health Financial Systems Ll	JTHERAN MUSCULOS	SKELETAL CENTER	R	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	pared: 1 am
		OTHER GENERAL			INTERNS &	
		SERVI CE			RESI DENTS	
Cost Center Description	SOCI AL SERVI CE	S	NONPHYSI CI AN	NURSING SCHOOL		
			ANESTHETI STS		Y & FRINGES	
	17.00	18.00	19.00	20.00	21.00	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE COSTS	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	-					
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	51, 334	0		0 0	0	118.00
NONREI MBURSABLE COST CENTERS					-	1.00.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191.00 19100 RESEARCH	0	0		0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194.0007950 MARKETI NG	0	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0		194.01
200.00 Cross Foot Adjustments		-		0 0		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118-201)	51, 334	0	I	0 0	0	202.00

	Financial Systems LL LLLOCATION - GENERAL SERVICE COSTS	ITHERAN MUSCULOS	Provi der C		Period: From 01/01/2016	eu of Form CMS- Worksheet B Part I	2002 10
					To 12/31/2016	Date/Time Pre	
		INTERNS &				5/31/2017 9:4	
	Cost Center Description	RESI DENTS SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
	cost center bescription	PRGM COSTS	PRGM	Subtotal	Residents Cost		
					& Post		
					Stepdown Adjustments		
		22.00	23.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS					1	1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00 18.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES						17.00 18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20.00	02000 NURSI NG SCHOOL						20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0					21.00 22.00
22.00	02300 PARAMED ED PRGM	0	0				22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	I I		1		1	
30.00	03000 ADULTS & PEDIATRICS	0	0	5, 444, 6		5, 444, 692	
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0 0		
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0		0 0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0	0		0 0		
41.00	04300 NURSERY	0	0		0 0		
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45.00	04500 NURSING FACILITY	0	0		0 0		
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	<u>/</u>	46.00
50.00	05000 OPERATI NG ROOM	0	0			16, 400, 424	50.00
51.00	05100 RECOVERY ROOM	0	0	697, 6	39 0		
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0				
	05400 RADI OLOGY-DI AGNOSTI C	0	0		-		54.00
	03630 ULTRA SOUND	0	0	5, 0	75 0		54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	2,0	0 0	0 0 2,008	
57.00	05700 CT SCAN	0	0	4,8		4,873	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	81, 0		81, 054	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	421.0	0 0		
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	431, 9	0 0	431, 962 0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0 0		
65.00	06500 RESPIRATORY THERAPY	0	0	20, 7	23 0	20, 723	
66.00	06600 PHYSI CAL THERAPY	0	0	4, 278, 6		4, 278, 619	
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
67.00			0	25, 9	0 0	0 0 25, 999	
68.00	06800 SPEECH PATHOLOGY 06900 FLECTROCARDI OLOGY	0					
68. 00 69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	20,7	0 0	0 0	70.00
68.00 69.00 70.00 71.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 0	0	1, 214, 8		1, 214, 826	71.00
68.00 69.00 70.00 71.00 72.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	000000000000000000000000000000000000000	000000000000000000000000000000000000000	1, 214, 8 20, 605, 4	49 0	1, 214, 826 20, 605, 449	71.00
68.00 69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0 0 0 0 0 0	1, 214, 8 20, 605, 4 2, 719, 0	49 0 30 0	1, 214, 826 20, 605, 449 2, 719, 030	71.00 72.00 73.00
68.00 69.00 70.00 71.00 72.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART)		0 0 0 0 0 0	1, 214, 8 20, 605, 4 2, 719, 0	49 0	1, 214, 826 20, 605, 449	71.00 72.00 73.00 74.00
68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS			1, 214, 8 20, 605, 4 2, 719, 0	49 0 30 0 34 0	1, 214, 826 20, 605, 449 2, 719, 030 34	71.00 72.00 73.00 74.00 75.00
68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C			1, 214, 8 20, 605, 4 2, 719, 0	49 0 30 0 34 0	1, 214, 826 20, 605, 449 2, 719, 030 34 0 0	71.00 72.00 73.00 74.00 75.00 88.00
68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00 89.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS			1, 214, 8 20, 605, 4 2, 719, 0	49 0 30 0 34 0	1, 214, 826 20, 605, 449 2, 719, 030 34	71.00 72.00 73.00 74.00 75.00 88.00 89.00
68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00 91.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER			1, 214, 8 20, 605, 4 2, 719, 0	49 0 30 0 34 0	1, 214, 826 20, 605, 449 2, 719, 030 34 0 0 0 0 0 0 0	71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00

LUTHERAN	MUSCULOSKE	LETAL	CENT	ER	
		Provi	der	CCN:	15-0

CENTER	2	In Lieu of Form CMS-2552-10				
ider CCN: 15-0168		Period: Worksheet B From 01/01/2016 Part I To 12/31/2016 5/31/2017 9:41 am				
ED ED GM	Subtotal	Inter Resident		Total		

					<u> 5/31/2017 9:4</u>	<u>1 am</u>
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	22.00	23.00	24.00	25.00	26.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		o o	0	97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 H0SPI CE	0	0		0 C		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0	52, 550, 59	0 0	52, 550, 590	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191. 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	29, 86	1 0		192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
194. 00 07950 MARKETI NG	0	0	2, 668, 54	0	2, 668, 547	
194. 01 07951 SENI OR CI RCLE	0	0	-7, 43			194.00
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118-201)	0	0	55, 241, 56	6 0		
		0	1 00,211,00	0	00,211,000	1-02.00

	Financial Systems LU TION OF CAPITAL RELATED COSTS	JTHERAN MUSCULOS	Provider CC	CN: 15-0168 F	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/31/2017 9:4	epared:
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS				1		
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	(0	0	
5.00	00500 ADMINI STRATI VE & GENERAL	0	40, 177	61, 860	102, 037	0	
7.00	00700 OPERATION OF PLANT	0	297, 493	458, 051	755, 544	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(0	0	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	(0	9.00 10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	(0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	(-	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	75, 283	115, 914	191, 197	0	14.00
15.00	01500 PHARMACY	0	0	(-	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0	(0	0	
17.00 18.00	01850 OTHER GENERAL SERVICES	0	0	(0	17.00 18.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	(0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	(0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(-	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(-	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		<u> </u>	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	0	183, 079	281, 888	3 464, 967	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	(0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	0	0	(0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0	
40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	(0	
41.00	04100 SUBPROVIDER - IRF	0	0	(0	0	
43.00	04300 NURSERY	0	0	(0 0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	(0 0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	(-	0	
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0			0	40.00
50.00	05000 OPERATING ROOM	0	402, 366	619, 521	1, 021, 887	0	50.00
51.00	05100 RECOVERY ROOM	0	112, 567	173, 320		0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	(0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	25, 788	39, 706	65, 494	0	
54.01		0	0	(0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	(0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	
60.00	06000 LABORATORY	0	0	(0 0	0	
60. 01	06001 BLOOD LABORATORY	0	0	(0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	
66.00	06600 PHYSI CAL THERAPY	0	184, 606	284, 238	3 468, 844	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	(0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	(0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	ſ		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	
		0	0	(0	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	(0 0	0	75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0 0	0	
90.00	09000 CLINIC	0	0	(0	0	
91.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0	(0 0	0	91.00 92.00
02 00		i i			1 UI		
92.00	OTHER REIMBURSABLE COST CENTERS				-		72.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER)	In Li	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/201	Worksheet B	2002 10
				To 12/31/201	6 Date/Time Pre 5/31/2017 9:4	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	P Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFI TS DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
95.00 09500 AMBULANCE SERVICES	0	0		0	0 (95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0 0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0 0	
98.00 09850 OTHER REIMBURSABLE COSTS	0	0		0	0 0	
99. 00 09900 CMHC	0	0		0	0 0	
99. 10 09910 CORF	0	0		0	0 0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0 (101.00
SPECIAL PURPOSE COST CENTERS				-	-	
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0	0		0	U U	111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	114.00
116. 00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 321, 359	2, 034, 4	98 3, 355, 85		118.00
NONREI MBURSABLE COST CENTERS	ч Ч	1, 521, 557	2,004,4	70 3, 333, 03		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0 0	190.00
191. 00 19100 RESEARCH	0	0		0	0 0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0 0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0	0 0	193.00
194. 00 07950 MARKETI NG	0	0		0	0 0	194.00
194.0107951 SENIOR CIRCLE	0	0		0	0 0	194.01
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0		201.00
202.00 TOTAL (sum lines 118-201)	0	1, 321, 359	2, 034, 4	98 3, 355, 85	7 (202.00

	Financial Systems L	UTHERAN MUSCULOS	KELETAL CENTER		In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLOU	ATTON OF CAPITAL RELATED COSTS		FIOVICEIC	F	rom 01/01/2016 o 12/31/2016	Part II	pared:
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	5/31/2017 9: 4 DI ETARY	
	Cost center bescription	& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	102, 037					5.00
7.00	00700 OPERATION OF PLANT	4,039	759, 583				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	229	C				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	855 768	0	0		768	9.00 10.00
12.00	01200 MAINTENANCE OF PERSONNEL	000	0			0	12.00
13.00	01300 NURSING ADMINISTRATION	2, 206	C	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 171	58, 132	1		0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 340 1, 495	0			0	15.00
17.00	01700 SOCIAL SERVICE	95	0	0	-	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	20.00
21.00	02200 I &R SERVICES-SALARI & TRINGES APPRVD	0	0	0	0	0	21.00
23.00	02300 PARAMED ED PRGM	0	C	0	0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS				150		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 368 0	141, 370 C	1		768 0	30.00
32.00	03200 CORONARY CARE UNIT	0	C			0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0	0	40.00
41.00	04300 NURSERY	0	0	0	0	0	41.00
44.00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	-	-	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0	0	46.00
50.00	05000 OPERATING ROOM	25, 814	310, 697	41	351	0	50.00
51.00	05100 RECOVERY ROOM	648	86, 922	0		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 979	19, 913	0	22	0	53.00 54.00
54.01	03630 ULTRA SOUND	9	0		0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	4	0	0	0	0	56.00
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	9 149	0		0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	782	C	0	0	0	•
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0	0	0	•
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	37 6, 918	142, 549		160	0	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	0, 710	142, 347	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	0	0	0	68.00
69.00		47	0	0	0	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 1, 725	0		0	0	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	34, 088	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 280	C	0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVI CE COST CENTERS	0	C	0	0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	
90.00 91.00	09000 CLI NI C 09100 EMERGENCY	0	0	0	0	0	90.00 91.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	U			0	91.00
00	OTHER REI MBURSABLE COST CENTERS			ı			1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95.00 96.00	09500 AMBULANCE SERVICES	0	0	0	0	0	
96.00 97.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	•
98.00	09850 OTHER REI MBURSABLE COSTS	0	C	0	0	0	

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2016	Worksheet B Part	
				To 12/31/2016	Date/Time Pre	pared:
					5/31/2017 9:4	1 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	7.00	LINEN SERVICI 8.00	9,00	10.00	
99. 00 09900 CMHC	0.00	0	0.00	0 0		99.00
99. 10 09910 CORF	0	0		0 0		99, 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	97, 055	759, 583	22	9 855	768	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191.00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	55	0		0 0		192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 MARKETI NG	4, 927	0		0 0		193.00 194.00
	4, 927	0		0 0		194.00
194.0107951 SENIOR CIRCLE 200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers		0		0		200.00
202.00 TOTAL (sum lines 118-201)	102, 037	759, 583	22	9 855		201.00
202.00 10TAL (Sum TITIES 110-201)	102,037	137, 303	22	1 000	700	1202.00

	2	UTHERAN MUSCULC	SKELETAL CENTER			u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	1	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	MAINTENANCE OF PERSONNEL		CENTRAL	PHARMACY	5/31/2017 9:4 MEDI CAL RECORDS &	
		PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY		LIBRARY	
	GENERAL SERVICE COST CENTERS	12.00	13.00	14.00	15.00	16.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON		2,206				12.00
13.00	01400 CENTRAL SERVICES & SUPPLY		0 2,200	253, 56	5		14.00
15.00	01500 PHARMACY	0	0 0		1,341		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	(0		0 0	1, 495	•
17.00 18.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES					0	17.00
18.00	01900 NONPHYSICIAN ANESTHETISTS				0 0	0	19.00
20.00	02000 NURSI NG SCHOOL		0 0		0 0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	(0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		-		0 0 0 0	0	22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(<u> </u>		0 0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	(646	2, 46	5 0	33	30.00
31.00	03100 I NTENSI VE CARE UNI T	(0 0		0 0	0	31.00
32.00	03200 CORONARY CARE UNIT	(0		0 0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				0 0 0 0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF				0 0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0 0		0 0	0	41.00
43.00	04300 NURSERY	0	0 0		0 0	0	43.00
44.00 45.00	04400 SKI LLED NURSI NG FACI LI TY				0 0 0 0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				0 0	0	45.00
10.00	ANCI LLARY SERVICE COST CENTERS		<u>, </u>				10.00
50.00	05000 OPERATI NG ROOM	(13, 21		654	50.00
51.00	05100 RECOVERY ROOM					78	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY					0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0 0	3	3 0	33	54.00
54.01	03630 ULTRA SOUND		0 0		0 0	0	54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	(0			0	55.00
	05700 CT SCAN					0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)				0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	(0 0		0 0	0	59.00
60.00	06000 LABORATORY	(0	6	9 0	14	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0 0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0 0		0 0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.				0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	(0 0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			1, 14		1 42	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY			1, 14		42	67.00
68.00	06800 SPEECH PATHOLOGY				0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY		0 0		0 0	1	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY			24.42		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			24, 49 196, 00		77 453	•
73.00	07300 DRUGS CHARGED TO PATIENTS		ol ol	16, 13		109	•
74.00	07400 RENAL DIALYSIS		0		0 0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	(0		0 0	0	75.00
88.00	OUTPATIENT SERVICE COST CENTERS				0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		ol ol		0 0	0	89.00
90.00	09000 CLI NI C				o o	0	90.00
91.00	09100 EMERGENCY	0	0 0		0 0	0	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	(0 0	0	94.00
94.00							
94.00 95.00	09500 AMBULANCE SERVICES	(0 0		0 0	0	95.00
						0 0 0	95.00 96.00

Health Financial Systems LL	JTHERAN MUSCULOS	KELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0168	Period: From 01/01/2016	Worksheet B Part II	
				To 12/31/2016		pared:
				_	5/31/2017 9:4	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	PERSONNEL	ADMI NI STRATI ON			RECORDS &	
	12.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
98.00 09850 OTHER REIMBURSABLE COSTS	12.00	13.00	14.00	15.00	18.00	98.00
98.00 10985010THER RETMBURSABLE COSTS 99.00 1099001 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0			0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	•	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	2, 206	253, 55	57 1, 341	1, 495	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0 0	0	190.00
191. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		8 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 MARKETI NG	0	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	o		0 0		194.01
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	2, 206	253, 56	5 1, 341	1, 495	202.00

		JTHERAN MUSCULO	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 01/01/2016		
					o 12/31/2016	Date/Time Pre 5/31/2017 9:4	
			OTHER GENERAL SERVI CE			I NTERNS & RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE		NONPHYSI CI AN	NURSING SCHOOL		
		17.00	18.00	ANESTHETI STS 19.00	20.00	Y & FRI NGES 21.00	
	GENERAL SERVICE COST CENTERS	17.00	10.00	19.00	20.00	21.00	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00							10.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15.00 16.00
	01700 SOCIAL SERVICE	95					17.00
18.00	01850 OTHER GENERAL SERVICES	0	0				18.00
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	(0		19.00 20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0				23.00
	03000 ADULTS & PEDIATRICS	95	0				30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0					31.00 32.00
	03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0				40.00 41.00
	04300 NURSERY	0	0				43.00
	04400 SKI LLED NURSI NG FACI LI TY	0	0				44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0					45.00 46.00
	ANCILLARY SERVICE COST CENTERS	-		1			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0				50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	0	0				53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0					54.00 54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
	05600 RADI OI SOTOPE	0	0				56.00 57.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	0				60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0					63.00 64.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0				66.00 67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					70.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0				74.00 75.00
	OUTPATIENT SERVICE COST CENTERS	-	-				
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88.00 89.00
	09000 CLINIC	0	0				90.00
	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	<u> </u>			92.00
	09400 HOME PROGRAM DI ALYSI S	0	0				94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0					95.00 96.00
70.00	10,000 DOIGDEE MEDIONE EQUIT MENTED	I 0	ı 0	1			, , , , , , , , , , , , , , , , , , , ,

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016		
		OTHER GENERAL SERVI CE			I NTERNS & RESI DENTS	
Cost Center Description	SOCI AL SERVI CE	S	NONPHYSI CI A ANESTHETI ST		SERVICES-SALAR Y & FRINGES	
	17.00	18.00	19.00	20.00	21.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0				98.00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0				99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS			•			1
105.00 10500 KIDNEY ACQUISITION	0	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUISITION	0	0				108.00
109. 00 10900 PANCREAS ACQUISITION	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0				115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	95	0		0 0	C	118.00
NONREI MBURSABLE COST CENTERS					-	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPAI D WORKERS	0	0				193.00
194. 00 07950 MARKETI NG	0	0				194.00
194. 01 07951 SENI OR CI RCLE	0	0				194.01
200.00 Cross Foot Adjustments				0 0	a a a a a a a a a a a a a a a a a a a	200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum Lines 118-201)	95	o o		0 0		202.00
			•		-	

ALLOCA	Financial Systems LU TION OF CAPITAL RELATED COSTS	JTHERAN MUSCULOS	Provi der C	CN: 15-0168	Period:	u of Form CMS- Worksheet B	2002 10
					From 01/01/2016 To 12/31/2016	Date/Time Pre	
		INTERNS &				5/31/2017 9:4	1 am
		RESI DENTS					
	Cost Center Description	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	Total	
			T KOM		& Post		
					Stepdown		
		22.00	23.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						10.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01850 OTHER GENERAL SERVICES						18.00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL						19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD						20.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0					22.00
23.00	02300 PARAMED ED PRGM		0				23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			618, 05	9 0	618, 059	30.00
	03100 I NTENSI VE CARE UNI T				0 0	018, 039	
	03200 CORONARY CARE UNI T				0 0	0	
	03300 BURN I NTENSI VE CARE UNI T				0 0	0	
	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF					0	
	04100 SUBPROVIDER - IRF					0	
	04300 NURSERY				0 0	0	
	04400 SKILLED NURSING FACILITY				0 0	0	
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE					0	
	ANCI LLARY SERVICE COST CENTERS					0	40.00
	05000 OPERATING ROOM			1, 374, 22		1, 374, 220	
	05100 RECOVERY ROOM			373, 63		373, 633	1
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY					0	
	05400 RADI OLOGY-DI AGNOSTI C			86, 47		86, 474	
	03630 ULTRA SOUND				9 0	9	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE				0 4 0	0	
	05700 CT SCAN				9 0	4 9	56.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)			14		149	
	05900 CARDI AC CATHETERI ZATI ON				0 0	0	
	06000 LABORATORY 06001 BLOOD LABORATORY			86	5 0	865 0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.				0 0	0	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY			3	0 0 8 0	0 38	
	06600 PHYSI CAL THERAPY			619, 65		619, 658	
	06700 OCCUPATI ONAL THERAPY					0	
	06800 SPEECH PATHOLOGY				0 0	0	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			4		48 0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			26, 29	-	26, 292	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			230, 54		230, 544	72.00
	07300 DRUGS CHARGED TO PATIENTS			20, 86		20, 865	
	07400 RENAL DIALYSES					0	
	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>	0	75.00
	08800 RURAL HEALTH CLINIC				0 0	0	88.00
88.00		1			o o	0	00 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY					0	90.00

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	२	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/31/2017 9:4	
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	22.00	23.00	24.00	25.00	26.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS				0 0	0	94.00
95.00 09500 AMBULANCE SERVICES				0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED				0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD				0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COSTS				0 0	0	98.00
99. 00 09900 CMHC				0 0	0	99.00
99. 10 09910 CORF				0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY				0 0	0	101.00
SPECIAL PURPOSE COST CENTERS				·		
105. 00 10500 KI DNEY ACQUI SI TI ON				0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON				0 0	0	106.00
107.00 10700 LIVER ACQUISITION				0 0		107.00
108.00 10800 LUNG ACQUISITION				0 0	0	108.00
109. 00 10900 PANCREAS ACQUISITION				0 0		109.00
110.00 11000 INTESTINAL ACQUISITION				0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON				0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				0 0	0	115.00
116. 00 11600 HOSPI CE				0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	3, 350, 8	67 0	3, 350, 867	
NONREI MBURSABLE COST CENTERS		`		<u> </u>		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0	0	190.00
191. 00 19100 RESEARCH				0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES				63 0		192.00
193. 00 19300 NONPALD WORKERS				0 0		193.00
194. 00 07950 MARKETI NG			4,9	27 0		194.00
194. 01 07951 SENI OR CI RCLE			., .	0 0		194.01
200.00 Cross Foot Adjustments	0	n		0 0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum Lines 118-201)	0	0	3, 355, 8	°	3, 355, 857	
		, ő	1 0,000,0		8, 888, 667	

	Financial Systems LL ALLOCATION - STATISTICAL BASIS	ITHERAN MUSCULO	SKELETAL CENTER	CN: 15-0168 P F	eriod: rom 01/01/2016		
				T	o 12/31/2016	Date/Time Pre 5/31/2017 9:4	
		CAPITAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	L			1	1	
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	123, 793	123, 793				1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			,		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 764	-			45, 020, 983	5.00
7.00	00700 OPERATION OF PLANT	27, 871	27, 871	46, 478	0	1, 782, 255	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	0	C			8.00
9.00	00900 HOUSEKEEPING	0	0	C	0	,	
10. 00 12. 00	01000 DI ETARY 01200 MAI NTENANCE OF PERSONNEL					338, 900 0	10.00 12.00
13.00	01300 NURSI NG ADMI NI STRATI ON			399, 674		-	
14.00	01400 CENTRAL SERVICES & SUPPLY	7,053	7, 053	401, 439	0	1, 840, 685	14.00
15.00	01500 PHARMACY	C	0	288			
16.00	01600 MEDI CAL RECORDS & LI BRARY				-		
17.00 18.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES				-		1
19.00	01900 NONPHYSI CI AN ANESTHETI STS				o o	0	19.00
20.00	02000 NURSI NG SCHOOL	C	0	C	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	C	0	C	-	0	21.00
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRVD					-	22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(<u> </u>			0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	17, 152	2 17, 152	2, 043, 603	0	3, 251, 749	30.00
31.00	03100 I NTENSI VE CARE UNI T	C	0 0		-		31.00
32.00	03200 CORONARY CARE UNIT			C		0	32.00
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T					0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF			C	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	C	0 0	C	0	0	41.00
43.00	04300 NURSERY	C	0	C	0	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY					0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE			C C	-	-	46.00
	ANCILLARY SERVICE COST CENTERS		1	1	1	1	
50.00	05000 OPERATING ROOM	37,696					50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	10, 546	10, 546				51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	o o	C	0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 416	2, 416	155, 978	0		1
54. 01 55. 00	03630 ULTRA SOUND						
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE			1, 300	-	1, 601	
57.00	05700 CT SCAN	C	0	C	0	3, 960	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	C	0	65, 962	
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY			4, 069		0	
60. 00 60. 01	06001 BLOOD LABORATORY			4,009		345, 015 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	l ő	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0 0	C	0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY			C	0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY					16, 309	
66.00	06600 PHYSI CAL THERAPY	17, 295	17, 295	2, 015, 003	0	3, 053, 022	
67.00	06700 OCCUPATI ONAL THERAPY	C	0	C	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	-	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			158 0		20, 619 0	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					761, 203	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		c c	0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	1, 447, 348	
74.00 75.00	07400 RENAL DIALYSIS				-	0	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	(<u>4 0</u>	n C	u U	1 0	/ 5.00
88.00	08800 RURAL HEALTH CLINIC	0	0 0	C	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		-	
90.00 91.00	09000 CLINIC 09100 EMERGENCY			0	0	0	90.00 91.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, U				91.00
		1	1	•	1	•	

	ncial Systems LL TION - STATISTICAL BASIS		SKELETAL CENTER		Peri od:	Worksheet B-1	2552-1
CUST ALLUCA	TION - STATISTICAL DASIS		Provider Co		From 01/01/2016	WULKSHEEL D-I	
					To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on	ADMI NI STRATI VE	
			(DOLLAR VALUE)	BENEFITS		& GENERAL	
			. ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00		SALARI ES)	5.4	5.00	<u> </u>
OTUE	R REIMBURSABLE COST CENTERS	1.00	2.00	4.00	5A	5.00	<u> </u>
	HOME PROGRAM DIALYSIS	0	0		0 0	0	94.0
	AMBULANCE SERVICES	0	0		0 0	0	1
	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
	DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
	OTHER REIMBURSABLE COSTS	0	0		0 0	0	
99.00 09900		0	0		0 0	0	
99.10 09910	CORF	0	0		0 0	0	99.1
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.0
	HOME HEALTH AGENCY	0	0		0 0	0	101. C
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0		0 0		105.0
	HEART ACQUI SI TI ON	0	0		0 0		106.0
	LIVER ACQUISITION LUNG ACQUISITION	0	0		0 0		107.0
	PANCREAS ACQUISITION	0	0		0 0		108.0
	INTESTINAL ACQUISITION	0	0				110.0
	I SLET ACQUI SI TI ON	0	0		0 0		1111. C
	INTEREST EXPENSE		0		0	, U	113.0
114.00 11400	UTILIZATION REVIEW-SNF						114.0
115.00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.0
116.00 11600		0	0		0 0	0	116. 0
118.00	SUBTOTALS (SUM OF LINES 1-117)	123, 793	123, 793	12, 259, 50	5 -10, 228, 018	42, 822, 179	118. C
	I MBURSABLE COST CENTERS	-				-	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	-	190.0
191.0019100		0	0		0 0		191.0
) PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0	85		24, 273	192.0
193.00 19300		0	0	1, 189, 01	0 0	2, 174, 531	
	SENIOR CIRCLE	0	0		0 7,435		194.0
200.00	Cross Foot Adjustments	0	0		7,433	0	200.0
201.00	Negative Cost Centers						201.0
202.00	Cost to be allocated (per Wkst. B,	1, 321, 359	2, 034, 498	2, 045, 86	3	10, 228, 018	202.0
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	10. 673940	16. 434677	0. 15211	4	0. 227183	202 0
203.00	Cost to be allocated (per Wkst. B,	10.073940	10. 434077	0.15211	0	102, 037	
204.00	Part II)				Ŭ.	102,037	204.0
205.00	Unit cost multiplier (Wkst. B, Part			0. 00000	o	0.002266	205.0
				0.0000	-	0.002200	[

		JTHERAN MUSCULO				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provider CO	F	eriod: rom 01/01/2016	Worksheet B-1	
				Т	o 12/31/2016	Date/Time Pre 5/31/2017 9:4	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS SERVED)	MAINTENANCE OF PERSONNEL	
		(SQUARE FEET)	(POUNDS OF	SERVI CE)	(MEALS SERVED)	(NUMBER	
		7.00	LAUNDRY) 8.00	9.00	10.00	HOUSED) 12.00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	12.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	92, 158					7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	140, 307 0	92, 158			8.00 9.00
10.00	01000 DI ETARY	0	0	0	15, 054		10.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	7,053	0	7, 053	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	0	0	16.00 17.00
	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	17, 152	115, 358	17, 152	15, 054	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	33.00 34.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0		0	0	43.00
	04500 NURSI NG FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50, 00	ANCI LLARY SERVI CE COST CENTERS	37, 696	24, 949	37, 696	0	0	50.00
51.00	05100 RECOVERY ROOM	10, 546		10, 546	0	0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00 53.00
	05400 RADI OLOGY -DI AGNOSTI C	2, 416	0	2, 416	0	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	55.00 56.00
	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0	0	59.00 60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	62.00 63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
		0	0	0	0	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	17, 295	0	17, 295	0	0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0 0	0 0	0	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	Ő	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)		0	0	0	0	74.00 75.00
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	-			
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
	09000 CLINIC	0	0	0	0	0 0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00

Health Financial Systems LU	THERAN MUSCULOS	KELETAL CENTER	ł	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF	
·	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	PERSONNEL	
	(SQUARE FEET)	(POUNDS OF	SERVI CE)		(NUMBER	
		LAUNDRY)			HOUSED)	
	7.00	8.00	9.00	10.00	12.00	07.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	-	97.00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0		0 0	0	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0		0	0	99.00
	0	0		0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		J 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0			, v	107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0				108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110,00
111. 00 11100 SLET ACQUI SI TI ON	0	0		0 0		111.00
113. 00 11300 I NTEREST EXPENSE	Ĵ	0				113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0		o o	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	92, 158	140, 307	92, 15	8 15,054	0	118.00
NONREI MBURSABLE COST CENTERS]
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 MARKETI NG	0	0		0 C		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0	0	194.01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 187, 153	124, 036	463, 04	1 415, 892	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	23. 732644	0. 884033	5.02442	5 27. 626677	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B,	759, 583	229	85	5 768	0	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	8. 242182	0. 001632	0. 00927	8 0. 051016	0. 000000	205.00

COST A	Financial Systems L ALLOCATION - STATISTICAL BASIS	UTHERAN MUSCULOS	Provider CC	N: 15-0168	Period: From 01/01/2016	u of Form CMS-2 Worksheet B-1	
					To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUI S.)	RECORDS & LI BRARY	(TIME SPENT)	
		(DI RECT NURS. HRS.)	(COSTED REQUI S.)		(GROSS CHARGES)		
		13.00	14.00	15.00	16.00	17.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
7.00	00700 OPERATI ON OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	6, 980, 346	22, 744, 332				13.00 14.00
15.00	01500 PHARMACY	0	22, 744, 332	1, 447, 44	8		15.00
16.00	01600 MEDICAL RECORDS & LI BRARY	0	0		0 486, 303, 088		16.00
17.00 18.00	01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CES	0	0			6, 364 0	17.00 18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0	0		0 0 0 0	0	21.00
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2,043,603	221, 075		0 10, 859, 032	6, 364	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 043, 003	221,075		0 10, 037, 032	0, 304	31.00
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0			0	43.00
45.00	04500 NURSI NG FACI LI TY	0	0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	46.00
50.00	05000 OPERATING ROOM	4, 936, 743	1, 185, 491		0 204, 894, 403	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 26, 160, 360	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0 0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 975		0 11, 073, 119	0	54.00
54.01	03630 ULTRA SOUND	0	0		0 127, 460	0	•
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0 0 0 25,802	0	00.00
	05700 CT SCAN	0	0		0 25, 802	0	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 64, 393	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 6, 182		0	0	59.00 60.00
60.00	06001 BLOOD LABORATORY	0	0, 102		0 4, 743, 200	0	60.01
61.00							61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0 0 0	0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
		0	0		0 426, 217	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	102, 706 0		0 14, 142, 553 0 0	0	66.00 67.00
		0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 418, 217	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 2, 196, 785		0 0 0 25, 797, 141	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	17, 580, 955		0 151, 164, 714	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	1, 447, 348	1, 447, 44		0	73.00 74.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0 20, 526 0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						1
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	88.00 89.00
	09000 CLINIC	0	0		0 0	0	1
91.00	09100 EMERGENCY	0	Ö		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
	09500 AMBULANCE SERVICES	0	o		0 0		95.00

Health Financial Systems LL	THERAN MUSCULOS	KELETAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016		oorod.
				10 12/31/2016	Date/Time Prep 5/31/2017 9:4	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DI RECT NURS.	(COSTED		(GROSS		
	HRS.)	REQUIS.)		CHARGES)		
	13.00	14.00	15.00	16.00	17.00	01.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0		96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09850 OTHER REI MBURSABLE COSTS	0	0		0 0	0	97.00 98.00
98.00 0985000THER REIMBURSABLE COSTS 99.00 09900 CMHC	0	0		0 0	0	98.00 99.00
99. 10 09910 CORF	0	0			0	99.00 99.10
100.0010000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		100.00
SPECIAL PURPOSE COST CENTERS	0	<u> </u>		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 980, 346	22, 743, 617	1, 447, 4	48 486, 303, 088	6, 364	118. 00
						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 715		0 0		191. 00 192. 00
192. 0019200 PHYSICIANS PRIVATE OFFICES 193. 0019300 NONPALD WORKERS	0	/15		0 0		192.00 193.00
194. 00 07950 MARKETI NG	0	0		0 0		193.00 194.00
194. 01 07951 SENI OR CI RCLE	0	0				194.00
200.00 Cross Foot Adjustments	0	Ű		0		200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	1, 194, 666	2, 461, 680	725, 6	809, 405		
Part I)		, ,				
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 171147	0. 108233	0. 5013	57 0. 001664	8. 066310	203.00
204.00 Cost to be allocated (per Wkst. B,	2, 206	253, 565	1, 34	41 1, 495	95	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000316	0. 011148	0.00092	0. 000003	0. 014928	205.00
11)				I		

	Financial Systems LL LLOCATION - STATISTICAL BASIS	JTHERAN MUSCULO		CN: 15-0168	Period: From 01/01/2016	worksheet B-1	
						Date/Time Pre	
		OTHER GENERAL			INTERNS &	5/31/2017 9: 4 RESI DENTS	
	Cost Center Description	SERVI CE		NURSING SCHOOL	SERVI CES-SALAR	SERVICES-OTHER	
		(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	Y & FRI NGES (ASSI GNED	PRGM COSTS (ASSI GNED	
		18.00	TIME) 19.00	TIME) 20.00	TI ME) 21.00	TIME) 22.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES	0					17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	C				19.00
	02000 NURSI NG SCHOOL	0	_	(D		20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			0		21.00
	02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0				0	22.00 23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
	03000 ADULTS & PEDIATRICS	0				0	
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0				0	
	03300 BURN I NTENSI VE CARE UNI T	0			0	0	
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	C		0 0	0	
40.00	04000 SUBPROVIDER - IPF	0	C		0 0	0	
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0				0	
	04400 SKILLED NURSING FACILITY	0	C		0 0	0	
45.00	04500 NURSING FACILITY	0	C		0 0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C)	0 0	0	46.00
50.00	05000 OPERATING ROOM	0	C		0 0	0	50.00
	05100 RECOVERY ROOM	0	C		0 0	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0				0	
	05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	
		0	C		0 0	0	0
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0				0	
	05700 CT SCAN	0				0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	с		o o	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0				0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			Ì			61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					0	
65.00	06500 RESPI RATORY THERAPY	0				0	
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0				0	
	06900 ELECTROCARDI OLOGY	0				0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		o o	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	0	
71.00	ATAOA LINDI DEVL AUADAED TA SATI EVITA	0				0	
71. 00 72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	∩		n (- V		1,0.00
71.00 72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			0 0	0	74.00
71.00 72.00 73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 0			0 0 0 0	0	
71.00 72.00 73.00 74.00 75.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS					0	75.00
71.00 72.00 73.00 74.00 75.00 88.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC						75.00 88.00
71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 0 0 0 0 0 0 0				0 0 0 0	75.00 88.00 89.00 90.00
71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00 91.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY					0	75.00 88.00 89.00 90.00 91.00
71.00 72.00 73.00 74.00 75.00 88.00 89.00 90.00 91.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					0 0 0 0	75.00 88.00 89.00 90.00

Health Financial Systems LL	JTHERAN MUSCULO	SKELETAL CENTEI	2	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre 5/31/2017 9:4	pared:
	OTHER GENERAL SERVI CE			INTERNS &	RESI DENTS	
Cost Center Description	S		NURSING SCHOO	LSERVI CES-SALAR		
	(TIME SPENT)	ANESTHETI STS	(10010155	Y & FRINGES	PRGM COSTS	
		(ASSI GNED TI ME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	(ASSIGNED TIME)	
	18.00	19.00	20.00	21.00	22.00	
95. 00 09500 AMBULANCE SERVI CES	0	C		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	C		0 0	0	98.00
99. 00 09900 CMHC	0	C		0 0	0	99.00
99. 10 09910 CORF	0	C		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	C		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	C)	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	0		J		0	1105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0			0 0 0 0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0			0 0		107.00
108. 0010800 LUNG ACQUISITION	0					107.00
109. 0010900 PANCREAS ACQUISITION	0					108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON						110.00
111. 00 11100 I SLET ACQUI SI TI ON	0			0 0		1111.00
113. 00 11300 I NTEREST EXPENSE				с С		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	c c		o o	0	115. OC
116.00 11600 HOSPI CE	0	C		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	C)	0 0	0	118.00
NONREI MBURSABLE COST CENTERS	T	I	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		0 0		190.00
191.00 19100 RESEARCH	0	C)	0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0 0		192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 MARKETI NG	0			0 0		193.00
194. 01 07951 SENI OR CI RCLE	0			0 0		194.00 194.01
200.00 Cross Foot Adjustments	0		,	0 0	0	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	0			0 0	n	201.00
Part I)						202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0, 000000	0. 000000	0. 00000	0 0. 000000	0, 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	0			0 0		204.00
Part II)					-	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0 0. 000000	0. 000000	205.00

		JTHERAN MUSCULOS		In Lieu of Form CN	
COST /	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0168	Period: Worksheet E From 01/01/2016	
				To 12/31/2016 Date/Time F 5/31/2017 9	
	Cost Center Description	PARAMED ED PRGM			
		(ASSI GNED			
		TI ME) 23.00			
	GENERAL SERVICE COST CENTERS	20100			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00					7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING				8. 00 9. 00
10.00	01000 DI ETARY				10.00
12.00					12.00
13.00 14.00					13.00
15.00					15.00
16.00					16.00
17.00 18.00					17.00 18.00
19.00					19.00
20.00					20.00
21.00 22.00					21.00
23.00		0			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 31.00		0			30.00
32.00		0			32.00
33.00		0			33.00
34.00 40.00		0			34. 00 40. 00
41.00		0			41.00
	04300 NURSERY	0			43.00
44.00 45.00		0			44.00 45.00
46.00		0			46.00
50.00	ANCI LLARY SERVICE COST CENTERS				
50.00 51.00		0			50.00
52.00		0			52.00
53.00		0			53.00
54.00 54.01		0			54.00 54.01
55.00		0			55.00
56.00		0			56.00
57.00 58.00		0			57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			59.00
	06000 LABORATORY	0			60.00
60.01 61.00		0			60. 01 61. 00
62.00		0			62.00
63.00		0			63.00
64.00 65.00		0			64.00 65.00
66.00		0			66.00
67.00		0			67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00		0			71.00
72.00 73.00		0			72.00
74.00		0			74.00
75.00		0			75.00
88.00	OUTPATIENT SERVICE COST CENTERS	0			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.00
90.00		0			90.00
91.00 92.00		0			91.00 92.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS				72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0			94.00
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0			95. 00 96. 00
70.00	UTOUL DURADLE MEDICAL EQUIP-RENIED	<u> </u>			70. UL

ealth Financial Systems	LUTHERAN MUSCULOSK			u of Form CMS-2552-
OST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0168	Peri od:	Worksheet B-1
			From 01/01/2016 To 12/31/2016	Date/Time Prepared
			10 12/31/2010	5/31/2017 9:41 am
Cost Center Description	PARAMED ED			
	PRGM			
	(ASSI GNED			
	TI ME)			
	23.00			
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97. (
B. 00 09850 OTHER REIMBURSABLE COSTS	0			98. (
9. 00 09900 CMHC	0			99. (
9. 10 09910 CORF	0			99. 1
00.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100. (
01.00 10100 HOME HEALTH AGENCY	0			101. (
SPECIAL PURPOSE COST CENTERS 05. 00 10500 KI DNEY ACQUI SI TI ON	0			105. (
06. 00 10600 HEART ACQUISITION	0			105.0
07. 00 10700 LIVER ACQUISITION	0			108.0
08. 00 10800 LUNG ACQUISITION	0			107.0
09. 00 10900 PANCREAS ACQUISITION	0			108.0
10. 00 11000 INTESTINAL ACQUISITION	0			1109.0
11. 00 11100 I SLET ACQUI SI TI ON	0			110.0
13. 00 11300 I NTEREST EXPENSE	0			111.0
14. 00 11400 UTI LI ZATI ON REVI EW-SNF				113. (
15. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			114.0
16. 00 11600 HOSPICE	0			115.0
18.00 SUBTOTALS (SUM OF LINES 1-117)	0			118.0
NONREI MBURSABLE COST CENTERS	0			110. 0
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. (
91. 00 19100 RESEARCH	0			191. (
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. (
93. 00 19300 NONPALD WORKERS	0			193. (
94. 00 07950 MARKETING	0			194. (
94. 01 07951 SENI OR CI RCLE	0			194.0
00.00 Cross Foot Adjustments				200. 0
01.00 Negative Cost Centers				200.0
02.00 Cost to be allocated (per Wkst. B,	0			201.0
Part I)				202.0
03.00 Unit cost multiplier (Wkst. B, Part	I) 0.000000			203. 0
04.00 Cost to be allocated (per Wkst. B,	0			200.0
Part II)				
05.00 Unit cost multiplier (Wkst. B, Part	0. 000000			205. (
				2001

	Financial Systems LI ATION OF RATIO OF COSTS TO CHARGES	UTHERAN MUSCULO	SKELETAL CENTEI Provi der C	CN: 15-0168 F	In Lie Period: From 01/01/2016 To 12/31/2016		epared:
			Title	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	5 444 400	1	5 444 400		5 444 (00	0.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 444, 692		5, 444, 692		5, 444, 692 0	1
	03200 CORONARY CARE UNIT					0	
	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	
	03400 SURGICAL INTENSIVE CARE UNIT	0		C	0 0	0	34.00
	04000 SUBPROVIDER - IPF	0		0	0	0	
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0				0	
	04400 SKI LLED NURSING FACILITY					0	
	04500 NURSI NG FACI LI TY	0			0	0	
46.00	04600 OTHER LONG TERM CARE	0		C	0	0	46.00
F0 00	ANCI LLARY SERVICE COST CENTERS	1/ 400 404	1	1/ 400 404		1/ 400 404	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	16, 400, 424 697, 639		16, 400, 424 697, 639		16, 400, 424 697, 639	
	05200 DELIVERY ROOM & LABOR ROOM	077,037		0,77,033		0,037	
53.00	05300 ANESTHESI OLOGY	0		C	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	618, 183		618, 183		618, 183	
	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	5,075		5,075		5, 075 0	
56.00	05600 RADI OLOGI - ITILKAFLUTT C	2,008		2,008	, i i i i i i i i i i i i i i i i i i i	2, 008	
57.00	05700 CT SCAN	4, 873		4, 873		4, 873	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	81, 054		81, 054	0	81, 054	
	05900 CARDI AC CATHETERI ZATI ON	0		0	, i	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	431, 962		431, 962	0	431, 962	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		C	0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0		0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	20, 723 4, 278, 619				20, 723 4, 278, 619	
67.00	06700 OCCUPATI ONAL THERAPY	4, 270, 017) 4, 2, 0, 01 2		4, 270, 017	
	06800 SPEECH PATHOLOGY	0	C) C	0 0	0	68.00
		25, 999		25, 999	0	25, 999	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 214, 826		1, 214, 826		0 1, 214, 826	
	07200 I MPL. DEV. CHARGED TO PATIENTS	20, 605, 449		20, 605, 449		20, 605, 449	1
	07300 DRUGS CHARGED TO PATIENTS	2, 719, 030		2, 719, 030		2, 719, 030	
	07400 RENAL DI ALYSI S	34		34	-		74.00
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	2	C	0 0	0	75.00
88.00	08800 RURAL HEALTH CLINIC	0		C) 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		C	0 0	0	
		0		0	0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	166, 699		166, 699		0 166, 699	
72.00	OTHER REIMBURSABLE COST CENTERS	100,077		100,077		100,077	72.00
	09400 HOME PROGRAM DI ALYSI S	0		C	0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	
	09700 DURABLE MEDICAL EQUIP-RENTED					0	
	09850 OTHER REIMBURSABLE COSTS	0			0	0	
99.00	09900 СМНС	0		C		0	1
	09910 CORF	0		0		0	
	10000 I & R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY						100.00
101.00	SPECIAL PURPOSE COST CENTERS					0	101.00
	10500 KIDNEY ACQUISITION	0		C			105.00
	10600 HEART ACQUI SI TI ON	0					106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION						107.00 108.00
	10900 PANCREAS ACQUISITION	0					109.00
110.00	11000 INTESTINAL ACQUISITION	0		C		0	110.00
	11100 I SLET ACQUI SI TI ON	0		C		0	111.00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVIEW-SNF						113.00 114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		r		n	115.00
115.00		, v	1	1	1		
	11600 HOSPI CE	0		(C)	0 52, 717, 289	116.00

Health Fina	ancial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0168		Period: From 01/01/2016	Worksheet C Part I		
					To 12/31/2016		pared: 1 am	
			Title	XVIII	Hospi tal	PPS		
					Costs			
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs		
		Part I, col.						
		26)						
		1.00	2.00	3.00	4.00	5.00		
201.00	Less Observation Beds	166, 699		166, 69	99	166, 699	201.00	
202.00	Total (see instructions)	52, 550, 590	0	52, 550, 59	0 0	52, 550, 590	202.00	

	Financial Systems LL ATION OF RATIO OF COSTS TO CHARGES	JTHERAN MUSCULOS	Provider C	CN: 15-0168 F	Peri od: From 01/01/2016 To 12/31/2016 Hospi tal	u of Form CMS-: Worksheet C Part I Date/Time Pre 5/31/2017 9:4 PPS	epared:
	· · · · · · · · · · · · · · · · · · ·		Charges			115	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	10 (70 270		10 (70)70			1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	10, 670, 370		10, 670, 370			30.00
32.00	03200 CORONARY CARE UNIT	0					32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0)		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0			34.00
	04000 SUBPROVIDER - IPF	0		0			40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0					41.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0					44.00
45.00	04500 NURSING FACILITY	0		0			45.00
46.00	04600 OTHER LONG TERM CARE	0)		46.00
-0.00	ANCI LLARY SERVICE COST CENTERS	01 004 240	112 000 0/2	204 004 402	0. 080043	0.00000	1 50 00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	91, 094, 340 12, 504, 747	113, 800, 063 13, 655, 613			0. 000000 0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	13, 033, 013) 20, 100, 300	0. 000000	0.000000	
53.00	05300 ANESTHESI OLOGY	0	C	0 0	0. 000000	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 424, 584	9, 648, 535			0.000000	
54.01 55.00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	113, 774	13, 686	127, 460	0. 039816 0. 000000	0. 000000 0. 000000	
55.00 56.00	05600 RADI OLOGY - THERAPEOTIC	25, 802		25, 802		0.000000	
57.00	05700 CT SCAN	0	7, 530			0.000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	64, 393	C	64, 393	1. 258739	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0.000000	0.000000	
50.00 50.01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 789, 361	955, 907	4, 745, 268	0. 091030 0. 000000	0.000000	
50. 01 51. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0. 000000 0. 000000	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ő		0. 000000	0.000000	
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0 0	0. 000000	0.000000	
54.00	06400 I NTRAVENOUS THERAPY	0	C) (0. 000000	0.000000	
55.00 56.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	319,601	106, 616			0.000000	
	06700 OCCUPATIONAL THERAPY	1, 855, 014	12, 287, 539	14, 142, 553	0. 302535 0. 000000	0. 000000 0. 000000	
	06800 SPEECH PATHOLOGY	0	0	0	0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	142, 414	275, 803	418, 217		0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	11 500 407		0.000000	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 267, 644 121, 836, 734	11, 529, 497 29, 327, 980			0. 000000 0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 898, 371	18, 477, 982			0.000000	
	07400 RENAL DI ALYSI S	20, 526	0	20, 526		0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0) (0. 000000	0.000000	75.00
38. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0				88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
	09000 CLINIC	0	C	0 0	0. 000000	0.000000	
	09100 EMERGENCY	0	0		0.00000	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	22, 852	165, 810	188, 662	0. 883585	0.000000	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0.00000	0. 000000	94.00
95.00	09500 AMBULANCE SERVI CES	0	C		0. 000000	0. 000000	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0. 000000	0.000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0.00000	0. 000000 0. 000000	
	09850 OTHER REI MBURSABLE COSTS 09900 CMHC	0	U		0. 000000	0.000000	98.00 99.00
	09910 CORF	0	0				99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	C	0			100.00
101.00	10100 HOME HEALTH AGENCY	0	0) ()		101.00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0	0				105.00
	10600 HEART ACQUISITION	0	C				106.00
107.00	10700 LIVER ACQUISITION	0	C				107.00
	10800 LUNG ACQUISITION	0	C	0 0			108.00
	10900 PANCREAS ACQUI SI TI ON	0	0				109.00
	11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON	0	0				110.00
	11300 INTEREST EXPENSE		0				113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0 0			115.00
116 00	11600 HOSPICE Subtotal (see instructions)	0 276, 050, 527	0 210, 252, 561	486, 303, 088			116.00 200.00
200.00							

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-0168		Worksheet C Part I	
				From 01/01/2016 To 12/31/2016		
		Title	Hospi tal	PPS		
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
202.00 Total (see instructions)	276, 050, 527	210, 252, 561	486, 303, 08	8		202.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0168	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2552 Worksheet C Part I Date/Time Prepare
		Title XVIII	Hospi tal	5/31/2017 9:41 an PPS
Cost Center Description	PPS Inpatient			
	Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
0. 00 03000 ADULTS & PEDIATRICS				30
. 00 03100 INTENSIVE CARE UNIT				31
. 00 03200 CORONARY CARE UNIT				32
. 00 03300 BURN INTENSIVE CARE UNIT				33
. 00 03400 SURGICAL INTENSIVE CARE UNIT				34
0.00 04000 SUBPROVIDER - IPF				40
. 00 04100 SUBPROVIDER - IRF				41
00 04300 NURSERY 00 04400 SKILLED NURSING FACILITY				43
00 04400 SKIELED NORSING FACILITY				44
0. 00 04500 OTHER LONG TERM CARE				45
ANCI LLARY SERVICE COST CENTERS				40
0. 00 05000 OPERATING ROOM	0. 080043			50
. 00 05100 RECOVERY ROOM	0. 026668			51
. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
. 00 05300 ANESTHESI OLOGY	0. 000000			53
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 055827			54
. 01 03630 ULTRA SOUND	0. 039816			54
. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000			55
. 00 05600 RADI OI SOTOPE	0. 077823			56
.00 05700 CT SCAN .00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.647145			57
	1. 258739			58
. 00 05900 CARDI AC CATHETERI ZATI ON . 00 06000 LABORATORY	0. 000000 0. 091030			59 60
. 01 06001 BLOOD LABORATORY	0.000000			60
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63
. 00 06400 I NTRAVENOUS THERAPY	0.000000			64
00 06500 RESPI RATORY THERAPY	0. 048621			65
0. 00 06600 PHYSI CAL THERAPY	0. 302535			66
00 06700 OCCUPATI ONAL THERAPY	0. 000000			67
00 06800 SPEECH PATHOLOGY	0. 000000			68
0. 00 06900 ELECTROCARDI OLOGY	0. 062166			69
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 047091			71
00 07200 TMPL. DEV. CHARGED TO PATIENTS	0. 136311 0. 074747			72
. 00 07400 RENAL DIALYSIS	0.001656			74
. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75
OUTPATIENT SERVICE COST CENTERS				
. 00 08800 RURAL HEALTH CLINIC				88
. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89
. 00 09000 CLINIC	0. 000000			90
. 00 09100 EMERGENCY	0. 000000			91
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 883585			92
	0.000000			
. 00 09400 HOME PROGRAM DI ALYSI S	0.000000			94
. 00 09500 AMBULANCE SERVICES . 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000 0. 000000			95
. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0.000000			90
. 00 09850 OTHER REIMBURSABLE COSTS	0.000000			98
. 00 09900 CMHC				99
. 10 09910 CORF				99
0.00 10000 I &R SERVICES-NOT APPRVD PRGM				100
1.00 10100 HOME HEALTH AGENCY				101
SPECIAL PURPOSE COST CENTERS				
5. 00 10500 KIDNEY ACQUISITION				105
6.00 10600 HEART ACQUI SI TI ON				106
7. 00 10700 LIVER ACQUISITION				107
B. 00 10800 LUNG ACQUI SI TI ON				108
9. 00 10900 PANCREAS ACQUISITION				109
0. 00 11000 INTESTINAL ACQUISITION				110
1.00 11100 I SLET ACQUI SI TI ON				111
3.00 11300 INTEREST EXPENSE				113
4.00 11400 UTILIZATION REVIEW-SNF 5.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				114
5.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 6.00 11600 HOSPICE				115
0.00 Subtotal (see instructions)				200
11.00 Less Observation Beds				200
12.00 Total (see instructions)				201

	Financial Systems LU TION OF RATIO OF COSTS TO CHARGES	UTHERAN MUSCULO	Provi der C	CN: 15-0168	Peri od: From 01/01/2016 To 12/31/2016		pared:
			Ti tl	e XIX	Hospi tal	5/31/2017 9:4 Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	1	- 1		
	03000 ADULTS & PEDIATRICS	5, 444, 692		5, 444, 69		5, 444, 692	•
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0			0 0	0	
	03300 BURN INTENSIVE CARE UNIT	0				0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0	
	04000 SUBPROVIDER - IPF	0			0 0	0	1
41.00	04100 SUBPROVI DER – I RF	0			0 0	0	41.00
43.00	04300 NURSERY	0			0 0	0	43.00
	04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
	04500 NURSING FACILITY	0			0 0	0	
	04600 OTHER LONG TERM CARE	0			0 0	0	46.00
	ANCILLARY SERVICE COST CENTERS	16, 400, 424		16, 400, 42	4 0	16, 400, 424	50.00
	05100 RECOVERY ROOM	697, 639		697, 63		697, 639	•
	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
	05300 ANESTHESI OLOGY	0			0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	618, 183		618, 18	3 0	618, 183	
	03630 ULTRA SOUND	5,075		5, 07	5 0	5, 075	
	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
	05600 RADI OI SOTOPE	2,008		2,00		2,008	1
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 873 81, 054		4, 87 81, 05		4, 873 81, 054	1
	05900 CARDI AC CATHETERI ZATI ON	01,034			0 0	01,054	1
	06000 LABORATORY	431, 962		431, 96	° °	431, 962	
	06001 BLOOD LABORATORY	0			0 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	
	06400 I NTRAVENOUS THERAPY	0		20.72	0 0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	20, 723 4, 278, 619				20, 723 4, 278, 619	•
	06700 OCCUPATI ONAL THERAPY	4, 270, 019			0 0	4, 270, 019	1
	06800 SPEECH PATHOLOGY	0	0)	0 0	0	
69.00	06900 ELECTROCARDI OLOGY	25, 999		25, 99	9 0	25, 999	69.00
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1, 214, 826		1, 214, 82		1, 214, 826	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 605, 449		20, 605, 44		20, 605, 449	•
	07300 DRUGS CHARGED TO PATLENTS 07400 RENAL DLALYSES	2, 719, 030		2, 719, 03	4 0	2, 719, 030	74.00
	07500 ASC (NON-DISTINCT PART)	0		-	0 0	0	
	DUTPATIENT SERVICE COST CENTERS	-					1
	08800 RURAL HEALTH CLINIC	0			0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
		0			0 0	0	
	09100 EMERGENCY	166, 699		166, 69		0 166 600	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	100,099	1	1 100, 09	1	166, 699	72.00
	09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
95.00	09500 AMBULANCE SERVICES	0			0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	
	09850 OTHER REIMBURSABLE COSTS	0			0 0	0	
	09900 CMHC 09910 CORF	0			0	0	
	10000 I & R SERVICES-NOT APPRVD PRGM	0			0	0	99.10 100.00
	10100 HOME HEALTH AGENCY	0			0		101.00
	SPECIAL PURPOSE COST CENTERS		1		- <u>,</u> ,	-	
105.00	10500 KIDNEY ACQUISITION	0			0		105.00
	10600 HEART ACQUI SI TI ON	0			0		106.00
	10700 LIVER ACQUISITION	0			0		107.00
	10800 LUNG ACQUISITION	0			U I		108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0					109.00 110.00
	11100 I SLET ACQUI SI TI ON				0		111.00
	11300 INTEREST EXPENSE				~	0	113.00
	11400 UTI LI ZATI ON REVI EW-SNF	1					114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116.00 200.00	11600 HOSPI CE	0			0		116.00
	Subtotal (see instructions)	52, 717, 289	0	52, 717, 28	9 0	52, 717, 289	1200 00

Health Financial Systems		LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0168		Period: From 01/01/2016 To 12/31/2016			
			Titl	e XIX	Hospi tal	Cost		
					Costs			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	BERCE Di sal l owance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
201.00	Less Observation Beds	166, 699		166, 69	99	166, 699	201.00	
202.00	Total (see instructions)	52, 550, 590	0	52, 550, 59	90 0	52, 550, 590	202.00	

	n Financial Systems I TATION OF RATIO OF COSTS TO CHARGES		KELETAL CENTER Provider CCN: 15-0168		Period: From 01/01/2016 To 12/31/2016	Date/Time Prepared:	
			Titl	e XIX	Hospi tal	5/31/2017 9:41 am Cost	
			Charges	<u>o /// /</u>	illoopi tui		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	10 / 70 070		10 / 70 07	10		20.00
30.00		10, 670, 370		10, 670, 37	0		30.00
31.00		0			0		31.00
32.00 33.00		0			0		32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
40.00		0			0		40.00
41.00		0			0		41.00
43.00		0			0		43.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
45.00		0			0		45.00
46.00	04600 OTHER LONG TERM CARE	0			0		46.00
	ANCI LLARY SERVICE COST CENTERS						
50.00		91, 094, 340	113, 800, 063	204, 894, 40	0. 080043	0. 000000	50.00
51.00		12, 504, 747	13, 655, 613	26, 160, 36		0. 000000	
52.00		0	0		0 0.000000	0.00000	
53.00	05300 ANESTHESI OLOGY	0	0 (40 505		0 0.00000	0.00000	
54.00		1, 424, 584	9, 648, 535			0. 000000	
54.01	03630 ULTRA SOUND	113, 774	13, 686	127, 46		0. 000000 0. 000000	
55.00 56.00		25, 802	0	25,80	0 0. 000000 02 0. 077823	0. 000000	
57.00	05700 CT SCAN	25, 602	7, 530			0. 000000	
58.00		64, 393	7, 550	64, 39		0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	04, 375	0	04, 35	0 0. 000000	0.000000	
60.00		3, 789, 361	955, 907	4, 745, 26		0.000000	
60.01	06001 BLOOD LABORATORY	0	0)	0 0.000000	0. 000000	
61.00		0	C		0 0.000000	0.00000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0.000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0.000000	0. 000000	63.00
64.00		0	0		0 0.000000	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	319, 601	106, 616	426, 21	0. 048621	0. 000000	65.00
66.00		1, 855, 014	12, 287, 539	14, 142, 55	0. 302535	0.00000	66.00
67.00		0	0		0 0.000000	0. 000000	
68.00		0	C		0 0.000000	0. 000000	
69.00		142, 414	275, 803	418, 21		0.00000	
70.00		0	11 500 407		0 0.00000	0.00000	
71.00		14, 267, 644	11, 529, 497			0.00000	
72.00 73.00		121, 836, 734 17, 898, 371	29, 327, 980			0.00000	
		20, 526	18, 477, 982 0			0. 000000 0. 000000	
	07500 ASC (NON-DI STI NCT PART)	20, 320	0		0 0.000000	0. 000000	
75.00	OUTPATIENT SERVICE COST CENTERS	0	U	/	0 0.000000	0.00000	/ / 3.00
88.00		0	0		0 0.000000	0.00000	88.00
89.00		0	0		0 0.000000	0. 000000	
		0	0		0 0.000000	0.000000	
91.00	09100 EMERGENCY	0	C		0 0.000000	0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	22, 852	165, 810	188, 66	0. 883585	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00		0	C)	0 0.000000	0. 000000	
		0	C		0 0.000000	0. 000000	
		0	0		0 0.000000	0.00000	
		0	0		0 0.000000	0.00000	
		0	0		0 0.000000	0.00000	
	09900 CMHC	0	0		U		99.00
	09910 CORF	0	0		0		99.10
	0 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00	0 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1	V		101.00
105 00	0 10500 KI DNEY ACQUI SI TI ON	0	C		0		105.00
	D 10600 HEART ACQUISITION	0	0		0		105.00
	0 10700 LIVER ACQUISITION	0	0		0		107.00
	0 10800 LUNG ACQUISITION	0	0		0		107.00
	D 10900 PANCREAS ACQUI SI TI ON	0	0		0		109.00
	0 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
	D 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
	011300 INTEREST EXPENSE		0				113.00
	0 11400 UTILIZATION REVIEW-SNF						114.00
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
115.00				1	1		
	0 11600 HOSPI CE	0	0)	0		116.00
	D 11600 HOSPI CE	0 276, 050, 527	0 210, 252, 561	486, 303, 08	0 38		116. 00 200. 00

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0168		Period: From 01/01/2016	Worksheet C	
				Part I Date/Time Prepared: 5/31/2017 9:41 am		
		Title XIX			Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
202.00 Total (see instructions)	276, 050, 527	210, 252, 561	486, 303, 08	8		202.00

Health Financial Systems	LUTHERAN MUSCULOS			u of Form CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES	5	Provider CCN: 15-0168	Peri od: From 01/01/2016 To 12/31/2016	
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00		· · · · · · · · · · · · · · · · · · ·	
INPATIENT ROUTINE SERVICE COST CE	NTERS			
30. 00 03000 ADULTS & PEDIATRICS				30.
31.00 03100 INTENSIVE CARE UNIT				31.
32.00 03200 CORONARY CARE UNI T				32.
33.00 03300 BURN INTENSIVE CARE UNIT				33.
34.00 03400 SURGICAL INTENSIVE CARE UNI	T			34.
40. 00 04000 SUBPROVIDER - IPF				40.
41.00 04100 SUBPROVIDER - IRF				41.
43. 00 04300 NURSERY				43.
44.00 04400 SKILLED NURSING FACILITY				44.
45.00 04500 NURSING FACILITY				45.
46.00 04600 OTHER LONG TERM CARE				46.
ANCILLARY SERVICE COST CENTERS	1			
50.00 05000 OPERATI NG ROOM	0. 000000			50.
51.00 05100 RECOVERY ROOM	0. 000000			51.
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
54.01 03630 ULTRA SOUND	0. 000000			54.
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.
56. 00 05600 RADI 0I SOTOPE	0. 000000			56.
57.00 05700 CT SCAN	0. 000000			57.
58.00 05800 MAGNETIC RESONANCE I MAGI NG				58.
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.
60. 00 06000 LABORATORY	0. 000000			60.
60.01 06001 BLOOD LABORATORY	0.000000			60.

	ANCILLARY SERVICE COST CENTERS		
50.00	05000 OPERATI NG ROOM	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	54.00
54.00	03630 ULTRA SOUND	0. 000000	54.00
55.00		0. 000000	55.00
	05500 RADI OLOGY-THERAPEUTI C		
56.00	05600 RADI OI SOTOPE	0. 000000	56.00
57.00	05700 CT SCAN	0. 000000	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	59.00
60.00	06000 LABORATORY	0. 000000	60.00
60.01	06001 BLOOD LABORATORY	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0. 000000	64.00
65.00	06500 RESPI RATORY 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
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400 RENAL DIALYSIS	0. 000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	75.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	08800 RURAL HEALTH CLINIC	0. 000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	89.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0. 000000 0. 000000	89.00 90.00
89.00 90.00 91.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0. 000000 0. 000000 0. 000000	89.00 90.00 91.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000 0. 000000	89.00 90.00
89.00 90.00 91.00 92.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00
89.00 90.00 91.00 92.00 94.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00
89.00 90.00 91.00 92.00 94.00 95.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I & SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.10 100.00 101.00 105.00 106.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 95.00 95.00 97.00 98.00 99.00 99.10 100.00 101.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.10 100.00 101.00 105.00 106.00 107.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09901 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 95.00 95.00 97.00 98.00 99.00 99.10 100.00 101.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 99.00 99.00 100.00 101.00 105.00 105.00 106.00 107.00 108.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 099010 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10800 LUNG ACQUI SI TI ON	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00 105.00 105.00 106.00 107.00 108.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 90.00 91.00 100.00 101.00 105.00 105.00 107.00 108.00 109.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10700 LI VER ACQUI SI TI ON 10800 LUNG ACQUI SI TI ON	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 99.00 99.00 99.00 90.00 010.00 101.00 105.00 105.00 106.00 107.00 108.00 109.00 110.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10600 LI VER ACQUI SI TI ON 10800 LING ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 110.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 90.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10600 LUNG ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON 10900 I NTESTI NAL ACQUI SI TI ON 11000 I NTESTI NAL ACQUI SI TI ON	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 110.00 111.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 101.00 110.00 111.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10600 HEART ACQUISITION 10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 100.00 101.00 105.00 106.00 107.00 108.00 109.00 110.00 111.00 111.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 100.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00 113.00 114.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-RENTED 09700 OURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I &R SERVI CES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10600 LUNG ACQUI SI TI ON 10800 LUNG ACQUI SI TI ON 10900 PANCREAS ACQUI SI TI ON 11000 I NTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 109.00 111.00 111.00 113.00 114.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 100.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00 113.00 114.00 115.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10600 LUNG ACQUISITION 10900 PANCREAS ACQUISITION 10900 PANCREAS ACQUISITION 11100 INTESTINAL ACQUISITION 11100 INTERST EXPENSE 11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.)	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00 111.00 114.00 115.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 90.00 91.00 90.00 91.00 00.00 01.00 105.00 107.00 108.00 109.00 111.00 113.00 114.00 116.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10700 LIVER ACQUISITION 10700 LIVER ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11100 ISLET ACQUISITION 11100 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 110.00 111.00 113.00 114.00 115.00 116.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 100.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00 113.00 114.00 115.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10700 LIVER ACQUISITION 10700 LIVER ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11100 ISLET ACQUISITION 11100 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 111.00 111.00 114.00 115.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 90.00 91.00 90.00 91.00 00.00 01.00 105.00 107.00 108.00 109.00 111.00 113.00 114.00 116.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS 09900 CMHC 09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION 10600 LUNG ACQUISITION 10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 INTESTINAL ACQUISITION 11100 INTERST EXPENSE 11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE Subtotal (see instructions)	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 109.00 110.00 111.00 113.00 114.00 115.00 116.00
89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 010.00 105.00 106.00 107.00 108.00 109.00 111.00 113.00 115.00 200.00	08900FEDERALLY QUALIFIED HEALTH CENTER09000CLINIC09100EMERGENCY092000BSERVATION BEDS (NON-DISTINCT PART)0THERREIMBURSABLE COST CENTERS09400HOME PROGRAM DIALYSIS09500AMBULANCE SERVICES09600DURABLE MEDICAL EQUIP-RENTED09700DURABLE MEDICAL EQUIP-SOLD09850OTHER REIMBURSABLE COSTS09900CMHC09910CORF10000I&R SERVICES-NOT APPRVD PRGM10100HOME HEALTH AGENCYSPECIAL PURPOSE COST CENTERS10500KIDNEY ACQUISITION10600HEART ACQUISITION10700LIVER ACQUISITION10800LNG ACQUISITION11000INTESTINAL ACQUISITION11100INTESTINAL ACQUISITION11300INTEREST EXPENSE11400UTILIZATION REVIEW-SNF11500AMBULATORY SURGICAL CENTER (D. P.)11600HOSPICESubtotal(see instructions)Less Observation Beds	0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	89.00 90.00 91.00 92.00 94.00 95.00 96.00 97.00 98.00 99.10 100.00 101.00 105.00 106.00 107.00 108.00 107.00 108.00 107.00 108.00 107.00 108.00 107.00 108.00 105.00 110.00 111.00 113.00 114.00 115.00 116.00 200.00

Health Financial Systems L	UTHERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				- I		
30.00 ADULTS & PEDIATRI CS 31.00 INTENSI VE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSI VE CARE UNIT 34.00 SUBGICAL INTENSI VE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSI NG FACILITY 45.00 NURSI NG FACILITY 200.00 Total (lines 30-199) Cost Center Description		Inpatient Program Capital Cost (col. 5 x col. 6)	618, 05 618, 05	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	31.00 32.00 33.00 34.00
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	2, 209 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provider C	CN: 15-0168	Period:	Worksheet D Part II	
				From 01/01/2016 To 12/31/2016		pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
'	Related Cost	(from Wkst. C,	to Charges	Program	, (column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	1, 374, 220				228, 245	50.00
51.00 05100 RECOVERY ROOM	373, 633				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	0.0000		0	
33. 00 05300 ANESTHESI OLOGY	0	j v	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	86, 474				10, 987	54.00
54.01 03630 ULTRA SOUND	9	127,100			0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	, s	0.00000		0	
56. 00 05600 RADI OI SOTOPE	4	25, 802			0	56.00
57.00 05700 CT SCAN	9	7, 530			0	57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	149				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.00000		0	59.00
0. 00 06000 LABORATORY	865	4, 745, 268			266	60.00
0. 01 06001 BLOOD LABORATORY	0	0	0.0000	0 00	0	60. 01
01.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000	0 00	0	62.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 00	0	63.00
4. 00 06400 I NTRAVENOUS THERAPY	0	0	0.0000	0 00	0	64.00
5. 00 06500 RESPI RATORY THERAPY	38	426, 217	0.0008	39 154, 596	14	65.00
6. 00 06600 PHYSI CAL THERAPY	619, 658	14, 142, 553	0. 04381	15 1, 841, 445	80, 683	66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0	C	0.0000	0 00	0	67. OC
8.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	48	418, 217	0.00011	15 142, 032	16	69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 00	0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 292	25, 797, 141	0.00101	19 4, 655, 408	4, 744	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	230, 544	151, 164, 714	0.00152	25 39, 151, 182	59, 706	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	20, 865	36, 376, 353	0.00057	74 6, 271, 481	3, 600	73.00
4.00 07400 RENAL DIALYSIS	0	20, 526	0.0000	00 11, 868	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.0000	0 00	0	75.00
OUTPATIENT SERVICE COST CENTERS		-				
38.00 08800 RURAL HEALTH CLINIC	0	0			0	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89.00
20. 00 09000 CLINIC	0	0	0.00000		0	90.00
P1. 00 09100 EMERGENCY	0	0	0.0000	0 00	0	91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	18, 923	188, 662	0. 10030	22, 852	2, 292	92.00
OTHER REIMBURSABLE COST CENTERS	-		1			
24. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	
25. 00 09500 AMBULANCE SERVICES						95.00
26. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.0000	0 00	0	96.00
7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.0000	0 00	0	97.00
28.00 09850 OTHER REIMBURSABLE COSTS	0	0	0.0000	0 00	0	98.00
200.00 Total (lines 50-199)	2, 751, 731	475, 632, 718		89, 148, 816	390, 553	200 00

Health Financial Systems	LUTHERAN MUSCULOS		C	India	eu of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER				Peri od:	Worksheet D	2332-10
				From 01/01/2016	Part III	
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swing-Bed	Total Costs	
	J	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
					minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	Ŭ	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0)	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0)		0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	33.00 34.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	0			0	40.00
40. 00 04000 SUBPROVIDER - TPF 41. 00 04100 SUBPROVIDER - TRF	0	0		0 0		40.00
43. 00 04300 NURSERY	0	0				41.00
44. 00 04400 SKILLED NURSING FACILITY	0	0			0	
45. 00 04500 NURSING FACILITY	0	0			0	
200.00 Total (lines 30-199)	0	0		0	-	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
30.00 03000 ADULTS & PEDIATRICS	(0.00	2.20	9 0		30, 00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	6, 565 0	0.00 0.00		9 0		30.00
32. 00 03200 CORONARY CARE UNIT	0	0.00		0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0.00				33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00		0 0		34.00
40, 00 04000 SUBPROVIDER - IPF	0	0.00		0 0		40.00
41. 00 04100 SUBPROVIDER - IRF	0	0.00		0 0		41.00
43. 00 04300 NURSERY	0	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0 C		45.00
200.00 Total (lines 30-199)	6, 565		2, 20	9 0	ł	200. 00

	JTHERAN MUSCULOSK	ELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Prep 5/31/2017 9:41	
	I		XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Nu Anesthetist Cost			Medical Education Cost	<u>4</u>)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			1		
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	50.00 51.00 52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0	0		0 0 0 0 0	0 0 0	53.00 54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0			0	55. 00 56. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0 0 0 0 0	0 0 0	57.00 58.00 59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0		0 0 0 0	0	60. 00 60. 01
61. 0006100PBPCLI NI CALLABSERVI CES-PRGMONLY62. 0006200WHOLEBLOOD & PACKEDREDBLOOD CELLS63. 0006300BLOODSTORI NG,PROCESSI NG & TRANS.	0	0		0 0 0 0	0	61.00 62.00 63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0 0		0 0 0 0 0 0	0 0 0	64.00 65.00 66.00
67. 00 06800 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 0 0 0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 0		0 0 0 0 0 0	0 0 0	69.00 70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0 0 0	0	72.00 73.00
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 0UTPATI ENT SERVICE COST CENTERS	0	0		0 0 0 0	0	74. 00 75. 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0 0	0 0	88. 00 89. 00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	90.00 91.00 92.00
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0 0 0	0	95.00 96.00 97.00
98.00 09850 OTHER REIMBURSABLE COSTS 200.00 Total (lines 50-199)	0	0		0 0 0 0	0	98.00 200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2016	Worksheet D Part IV	
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	pared: 1 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati 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)	7.00	0.00	7)	40.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
0. 00 05000 OPERATING ROOM	0	204, 894, 403	0.00000	0.00000	34, 030, 805	50.00
1. 00 05100 RECOVERY ROOM	0				34, 030, 803	51.00
2. 00 05200 DELIVERY ROOM & LABOR ROOM			0.00000		0	52.00
3. 00 05300 ANESTHESI OLOGY		-			0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C		-	1		1, 406, 946	54.00
4. 01 03630 ULTRA_SOUND			1		1, 400, 940	54.00
	0	127, 460			0	
5. 00 05500 RADI OLOGY-THERAPEUTI C 6. 00 05600 RADI OI SOTOPE		25, 802			0	55.00 56.00
	0				0	57.00
	0	7, 530			Ű	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
9.00 05900 CARDI AC CATHETERI ZATI ON	-	-	0.00000		0	59.00
	0	4, 745, 268			1, 460, 201	60.00
0.01 06001 BLOOD LABORATORY	0	0	0. 00000	0.00000	0	60.01
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	62.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	63.00
4.00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64.00
5.00 06500 RESPIRATORY THERAPY	0				154, 596	65.00
6.00 06600 PHYSI CAL THERAPY	0				1, 841, 445	66.00
7.00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
8.00 06800 SPEECH PATHOLOGY	0	-	0.00000		0	68.00
9.00 06900 ELECTROCARDI OLOGY	0	418, 217			142, 032	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				4, 655, 408	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				39, 151, 182	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0				6, 271, 481	73.00
4.00 07400 RENAL DIALYSIS	0				11, 868	
5. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0.00000	0	75.00
OUTPATIENT SERVICE COST CENTERS	1					
8.00 08800 RURAL HEALTH CLINIC	0	-			0	88.00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
0. 00 09000 CLINIC	0				0	90.00
1.00 09100 EMERGENCY	0				0	91.00
2.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	188, 662	0.00000	0.00000	22, 852	92.00
		2	0.00000	0 000000	2	04 00
4.00 09400 HOME PROGRAM DI ALYSI S	0	0	0. 00000	0.00000	0	94.00
5.00 09500 AMBULANCE SERVICES	-	-			-	95.00
6.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0				0	96.00
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-			0	97.00
8.00 09850 OTHER REIMBURSABLE COSTS	0	-		0.00000	0	98.00
00.00 Total (lines 50-199)	0	475, 632, 718			89, 148, 816	J200. 00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PASS	Provider C	CN: 15-0168	Peri od:	Worksheet D	
HROUGH COSTS				From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre	pared:
		Title	xviii	Hospi tal	5/31/2017 9:4 PPS	Iam
Cost Center Description	I npati ent	Outpatient	Outpatient		115	
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	-	Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	0	17, 732, 611		0		50.0
1.00 05100 RECOVERY ROOM	0	0		0		51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.0
3. 00 05300 ANESTHESI OLOGY	0	0		0		53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 231, 166		0		54.0
4. 01 03630 ULTRA SOUND	0	0		0		54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.0
5. 00 05600 RADI 0I SOTOPE	0	0		0		56.0
7. 00 05700 CT SCAN	0	0		0		57.0
B. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0		58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.0
D. 00 06000 LABORATORY	0	128, 319		0		60. C
D. 01 06001 BLOOD LABORATORY	0	0		0		60.0
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.0
4. 00 06400 I NTRAVENOUS THERAPY	0	0		0		64.0
5. 00 06500 RESPIRATORY THERAPY	0	20, 252		0		65.0
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	0	84, 290 0		0		66.0
3. 00 06800 SPEECH PATHOLOGY	0	0		0		67. C
2. 00 06800 SPEECH PATHOLOGY 2. 00 06900 ELECTROCARDI OLOGY	0	U דוד בדב		0		69.0
0. 00 07000 ELECTROCARDIOLOGI	0	272, 747		0		70.0
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 699, 214		0		71.0
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 180, 873		0		72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 487, 185		0		73.0
4. 00 07400 RENAL DIALYSIS	0	1,407,103		0		74.0
5. 00 07500 ASC (NON-DI STINCT PART)	0	0		0		75.0
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1	0		/ 0.0
B. 00 08800 RURAL HEALTH CLINIC	0	0		0		88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
D. 00 09000 CLINIC	0	0		0		90.0
1.00 09100 EMERGENCY	0	0		0		91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	56, 222		0		92.0
OTHER REI MBURSABLE COST CENTERS						1
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0		94.0
5. 00 09500 AMBULANCE SERVICES						95. C
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.0
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.0
3. 00 09850 OTHER REI MBURSABLE COSTS	0	0		0		98. C
00.00 Total (lines 50-199)	0	25, 892, 879		0		200.0

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0168	Peri od:	Worksheet D	
					From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	epared:
			Title	e XVIII	Hospi tal	5/31/2017 9:4 PPS	i am
				Charges	nospi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	· · · · · · · · · · · · · · · · · · ·	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins (see inst.)			
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS		2100	0.00		0.00	
50.00 0500	O OPERATING ROOM	0. 080043	17, 732, 611		0 0	1, 419, 371	50.00
51.00 0510	O RECOVERY ROOM	0. 026668	C		0 0	0	51.00
	O DELIVERY ROOM & LABOR ROOM	0. 000000	C		0 0	0	52.00
	O ANESTHESI OLOGY	0. 000000	0		0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 055827	1, 231, 166		0 0	68, 732	
	OULTRA SOUND	0. 039816	0		0 0	0	
	0 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	
	0 RADI OI SOTOPE	0. 077823	C		0 0	0	
	O CT SCAN	0. 647145	C		0 0	0	
	O MAGNETIC RESONANCE IMAGING (MRI)	1. 258739	0		0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
		0. 091030	128, 319		0 0	11, 681	
	1 BLOOD LABORATORY	0. 000000	C		0 0	0	
	0 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0 0	o	61.00
	0 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	
	0 INTRAVENOUS THERAPY	0.000000			0 0	0	
	0 RESPIRATORY THERAPY	0. 048621	20, 252		0 0	985	
	0 PHYSI CAL THERAPY	0. 302535	84, 290		0 0	25, 501	
	0 OCCUPATI ONAL THERAPY	0. 000000	01,2,0	1	0 0	20,001	
	O SPEECH PATHOLOGY	0. 000000	0		0 0	0	
	0 ELECTROCARDI OLOGY	0. 062166	272, 747		0 0	16, 956	
	0 ELECTROENCEPHALOGRAPHY	0. 000000	C		0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.047091	1, 699, 214		0 0	80, 018	
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0. 136311	3, 180, 873		0 0	433, 588	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 074747	1, 487, 185	39, 72	24 0	111, 163	73.00
74.00 0740	O RENAL DI ALYSI S	0. 001656	C		0 0	0	74.00
	O ASC (NON-DI STI NCT PART)	0. 000000	0		0 0	0	75.00
	ATIENT SERVICE COST CENTERS	-					
	O RURAL HEALTH CLINIC	0. 000000				0	
	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
		0. 000000	C		0 0	0	
	O EMERGENCY	0. 000000	0		0 0	0	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 883585	56, 222		0 0	49, 677	92.00
	R REIMBURSABLE COST CENTERS	0. 000000		1	0		94.00
	0 AMBULANCE SERVICES	0. 000000			0		94.00
	0 DURABLE MEDICAL EQUIP-RENTED	0.000000	C		0 0	0	
	0 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	O OTHER REIMBURSABLE COSTS	0. 000000			0 0	0	
200.00	Subtotal (see instructions)	0.00000	25, 892, 879			2, 217, 672	
201.00	Less PBP Clinic Lab. Services-Program		20,072,077		0 0	2,217,072	201.00
	Only Charges						

	LUTHERAN MUSCULOSK	ELETAL CENTER	2	In Lie	u of Form CMS-	2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider CC	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/31/2017 9:4	
			XVIII	Hospi tal	PPS	
	Cost					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subject To Ded. & Coins. D	Subject To Ded. & Coins.				
		(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01 03630 ULTRA SOUND	0	0				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
	0	0				60.0
50. 01 06001 BLOOD LABORATORY	0	0				60.0
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	0				63.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
68. 00 06800 SPEECH PATHOLOGY	0	0				68.0
59. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 969	0				73.0
74.00 07400 RENAL DIALYSIS	0	0				74.0
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.0
OUTPATIENT SERVICE COST CENTERS		-				
38.00 08800 RURAL HEALTH CLINIC	0	0				88.0
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.0
20. 00 09000 CLINIC	0	0				90.0
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.0
022.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0				92.0
24. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94.0
25. 00 09500 AMBULANCE SERVICES	0	Ŭ				95.0
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.0
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.0
28.00 09850 OTHER REIMBURSABLE COSTS	0	0				98.0
200.00 Subtotal (see instructions)	2,969	0				200.0
201.00 Less PBP Clinic Lab. Services-Program	n 0					201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 969	0				202.00

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:4	epared: 1 am
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS		-	1		-	
	O OPERATING ROOM	0. 080043	C		0 549, 059		
	O RECOVERY ROOM	0. 026668	C		0 0	-	
	O DELIVERY ROOM & LABOR ROOM	0. 000000	C		0 0	-	
	0 ANESTHESI OLOGY	0. 000000	C		0 0	0	
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 055827	0		0 36, 859	0	54.00
54.01 0363	O ULTRA SOUND	0. 039816	C		0 0	0	54.01
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55.00
56.00 0560	0 RADI OI SOTOPE	0. 077823	0		0 0	0	56.00
57.00 0570	O CT SCAN	0. 647145	C		0 0	0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	1. 258739	C		0 0	0	58.00
	O CARDI AC CATHETERI ZATI ON	0. 000000	C		0 0	0	59.00
	O LABORATORY	0. 091030	C		0 3, 051	0	60.00
	1 BLOOD LABORATORY	0. 000000	C		0 0	0	60.01
	O PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0	-	61.00
	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C		0 0	0	
	0 BLOOD STORING, PROCESSING & TRANS.	0. 000000	Ő		0 0	0	
	O I NTRAVENOUS THERAPY	0. 000000	Ő		0 0		
	O RESPI RATORY THERAPY	0. 048621	C		0 0		
	O PHYSI CAL THERAPY	0. 302535	C		0 51,960	-	
	0 OCCUPATI ONAL THERAPY	0. 000000	C C		0 0	0	
	O SPEECH PATHOLOGY	0. 000000	0		0 0	0	
	0 ELECTROCARDI OLOGY	0. 062166	0		0 3, 056		
	0 ELECTROENCEPHALOGRAPHY	0. 002100	0		0 3,030	0	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 43, 108	-	
	O IMPL. DEV. CHARGED TO PATIENTS	0. 136311	0		0 43, 108	0	
	O DRUGS CHARGED TO PATIENTS					-	
	0 RENAL DIALYSIS	0. 074747 0. 001656					
		0. 001858					
	O ASC (NON-DISTINCT PART) ATIENT SERVICE COST CENTERS	0.00000	0		0 0	0	/5.00
	ORURAL HEALTH CLINIC	0. 000000		1		0	88.00
						-	
	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
	O CLINIC	0. 000000	0		0 0	-	
	O EMERGENCY	0. 000000	0		0 0		
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0. 883585	0		0 0	0	92.00
	R REIMBURSABLE COST CENTERS			1	-		
	O HOME PROGRAM DI ALYSI S	0. 000000	_		0		94.00
	O AMBULANCE SERVICES	0. 000000	0		0		95.00
	O DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	-	
	O DURABLE MEDICAL EQUIP-SOLD	0. 000000	C		0 0	-	
	O OTHER REIMBURSABLE COSTS	0. 000000	C		0 0	0	
200.00	Subtotal (see instructions)		0		0 927, 416	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges Net Charges (line 200 +/- line 201)		C		0 927, 416		
202.00					0 927, 416		202.00

	UTHERAN MUSCULOS				u of Form CMS-2	2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prep 5/31/2017 9:47	
		Titl	e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	1			
ANCILLARY SERVICE COST CENTERS	_					
50. 00 05000 OPERATI NG ROOM	0	43, 948				50.0
51.00 05100 RECOVERY ROOM	0	0				51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
53. 00 05300 ANESTHESI OLOGY	0	0	1			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 058	1			54.0
54. 01 03630 ULTRA SOUND	0	0				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
56. 00 05600 RADI 0I SOTOPE	0	0				56.0
77.00 05700 CT SCAN	0	0				57.0
88.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	0				58.0 59.0
0. 00 06000 LABORATORY	0	278				60.0
0. 01 06001 BLOOD LABORATORY	0	2/8	1			60. C
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	'			61.0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. C
4. 00 06400 INTRAVENOUS THERAPY	0	0				64. C
5. 00 06500 RESPI RATORY THERAPY	0	0				65. C
6. 00 06600 PHYSI CAL THERAPY	0	15, 720				66. C
57. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.C
8.00 06800 SPEECH PATHOLOGY	0	0				68.0
9.00 06900 ELECTROCARDI OLOGY	0	190	1			69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 030				71.0
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS	0	8, 900				72.0
4. 00 07400 RENAL DIALYSIS	0	13, 083 0	1			73.C 74.C
5. 00 07500 ASC (NON-DI STINCT PART)	0	0				75.0
OUTPATIENT SERVICE COST CENTERS	0	0	1			/ 5. 0
8. 00 08800 RURAL HEALTH CLINIC	0	0				88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.0
0. 00 09000 CLINIC	0	0				90.0
1.00 09100 EMERGENCY	0	0				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)			92.0
OTHER REIMBURSABLE COST CENTERS	-					
4.00 09400 HOME PROGRAM DI ALYSI S	0	0				94. C
5. 00 09500 AMBULANCE SERVICES	0					95. C
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1			96.0
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1			97.0
8. 00 09850 OTHER REI MBURSABLE COSTS	0	0				98.0
00.00 Subtotal (see instructions)	0	86, 207				200.0
201.00 Less PBP Clinic Lab. Services-Program	0					201. C
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	0	86, 207				202. C
.uz. uu Inet charges (The 200 +/ - The 201)	0	00, 207	I		I	,202.0

Health Financial Systems

LOTTILITYIN	MOSCOLOSICE		OLIVI		
I I I THERAN	MUSCULOSKEI	FTΔI	CENT	FR	

In Lieu of Form CMS-2552-10

100 Inpatient days (including private room days, excluding swing-bed and nomeon days) 6.565 2.4 00 Private room days (excluding swing-bed and observation bed days) 6.364 4. 01 Semi-private room days (excluding swing-bed and observation bed days) 6.364 5. 02 Staing-bed SWF type inpatient days (including private room days) through becember 31 of the cost reporting period 6.4 03 Total swing-bed SWF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.4 04 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.4 05 Swing-bed SWF type inpatient days applicable to title XVII only (including private room days) after 10.4 05 Swing-bed SWF type inpatient days applicable to title XVII only (including private room days) after 11.4 06 Swing-bed SWF type inpatient days applicable to title XVI only (including private room days) 11.4 07 Swing-bed SWF type inpatient days applicable to title XVI only (including private room days) 11.4 08 Swing-bed SWF type inpatient days applicable to title XVI only (including private room days) 11.4 08 Swing-bed SWF type in	ealth Financia	al Systems LUTHERAN MUSCULOSKEI	LETAL CENTER	In Lie	u of Form CMS-2	2552-1
Interview Interview <t< th=""><th>OMPUTATION OF</th><th>INPATIENT OPERATING COST</th><th>Provider CCN: 15-0168</th><th>Peri od:</th><th>Worksheet D-1</th><th></th></t<>	OMPUTATION OF	INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od:	Worksheet D-1	
Cost Center Description Title XVIII Hospital FPS Vext I - ALL PRAVIDER COMMENTS 1.00 1.00 1.00 MARTIENT DAYS 1.00 1.00 1.00 MARTIENT DAYS 1.00 0.00 0.00 Impairent days (Including private room days, accluding axing-bed and nowbern days) 0.650 1.1 00 Impairent days (Including private room days, accluding axing-bed and nowbern days) 0.644 0.51 01 Impairent days (Including private room days, accluding axing-bed and nowbern days) 0.544 0.53 02 Intel Similaria 0.544 0.54 0.54 03 Intel Similaria 0.544 0.54 0.54 04 Intel Similaria 0.54 0.54 0.54 05 Total sing-bed NF type Inpairent days (Including private room days) after December 31 of the cost 0.54 0.54 05 Total sing-bed NF type Inpairent days (Including private room days) after December 31 of the cost 0.51 0.51 06 Total sing-bed NF type Inpairent days applicable to title XVII on y (Including private room days) 0.11 1.10					Dato/Timo Pro	parod
The XVIII Inspiral PPT Cost Conter Description 1.00 1.00 IMPAILED ASS 1.00 1.00 Impatient days (including private room days, and seing-bed and needern days). If you have nolly private room days, (actualing including and observation bed days). If you have nolly private room days, (actualing including private room days, (actualing private room days), If you have only private room days, (actualing private room days, (actualing private room days), If you have only private room days, (actualing private room days), If you have only private room days, (actualing private room days), If you have only private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have not actualing private room days, (actualing private room days), If you have				10 12/31/2010		
Cost Center Description 1.00 IMPLITER ALCONDUCER COMPONENTS 1.00 Implifted ADS 1.00 Implifted ADS 1.00 Implifted ADS 6.666 1.00 1.00 Private room days (acculating seing-bed and observation bed days). Through becember 31 of the cost 6.666 1.00 0.01 1.01 1.00 6.666 1.02 0.01 6.666 1.03 1.01 6.666 1.03 1.01 6.666 1.03 1.02 0.01 1.04 1.02 0.01 0.01 1.05 1.02 0.01 0.01 1.03 1.02 0.01 0.01 1.04 1.02 0.01 0.01 0.01 1.05 1.02 0.01 0.01 0.01 0.01 1.05 1.02 0.01 0.01 0.01 0.01 0.01 1.05 1.01 1.02 1.01 0.01 0.01 0.01 </th <th></th> <th></th> <th>Title XVIII</th> <th>Hospi tal</th> <th></th> <th>- cili</th>			Title XVIII	Hospi tal		- cili
PART 1 - ALL PROVIDER COMPONENTS IMPART DAYS Constraints Impartent days (including private room days and swing-bed days, excluding swing-bed and nestorm days) 6,565 10 Inpatient days (including private room days. excluding swing-bed and nestorm days) 6,565 11 Seel.private room days (excluding swing-bed and observation bed days) 6,565 12 Seel.private room days (excluding swing-bed and observation bed days) 6,566 12 Seel.private room days (excluding swing-bed and observation bed days) 6,566 12 Seel.private room days (excluding swing-bed and pass) 6,616 10 Intak swing bed (if calendar ywar, enter 0 on this line) 10 6,16 10 Total swing bed (if calendar ywar, enter 0 on this line) 10 10 10 10 Total swing bed (if calendar ywar, enter 0 on this line) 10 10 10 10 Seel.private room days (by spellipatient days (including private room days) 10 10 11 Total swing bed (if calendar ywar, enter 0 on this line) 10 10 10 11 Total swing bed (if calendar ywar, enter 0 on this line) 10 10	Сс	st Center Description				
IMPATTENT DAYS Insplicing days (including private room days and swing-bod days, excluding newborn) (6, 55) 1.1 00 Inpattent days (including swing-bod and observation bed days). (6, 556) 3.1 01 Frivate room days (accluding swing-bod and observation bed days). (7, 17) (8, 546) (8, 56)					1.00	
0.00 Inpatient days (including private room days, acxiduating newborn) 6, 556 1. 0.01 Inpatient days (including private room days, acxiduating swing-bed and observation bed days) 17 you have only private room days. 0. 0.02 Sami_private room days (excluding sing-bed and observation bed days) 17 you have only private room days. 0. 0.03 Sami_private room days. 1. 0. 5. 1. 0.03 Sami_private room days. 1. 0. 5. 1. 0.04 Sami_private room days. 1. 0. 5. 1. 0.05 Sami_private room days. 1. 0. 5. 1. 5. 1. 0.07 Tatal sami_p-bod XF type inpatient days (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31 of the cost reporting period (including private room days.) after December 31						
000 Inpatient days (including pariyabed and observation bed days). 6.565 2.1 001 Private room days (secular) saving-bed and observation bed days). 0.3 0.3 001 onto complete this line. 0.3 0.3 001 onto complete this line. 0.3 0.3 001 onto complete this line. 0.3 0.3 001 total simple days type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 0.3 001 Total simple days through period (if calendar year, enter 0 on this line). 0.3 0.4 001 Total simple days through period (if calendar year, enter 0 on this line). 0.3 0.4 001 Total simple days through period (if calendar year, enter 0 on this line). 0.3 0.4 001 Simple days Sift type inpatient days applicable to the Program (excluding private room days). 0.1 1.1 002 Simple days Sift type inpatient days applicable to this line). 0.3 1.3 003 Simple days Sift type inpatient days applicable to the Program (excluding private room days). 0.1 1.4 013 Simple days Sift type inpatinet days applicable to the Program (excluding private						
00 Private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. 0 3 01 Semi-private room days (excluding swing-bed and observation bed days) 6.3.44 4.1 02 Tatal swing-bed SF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 6.1 03 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 7 04 Total swing-bed SF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line) 8 05 Sind-bed SF type inpatient days applicable to the tit XVII only (including private room days) after December 31 of the cost reporting period (see instructions) 10 05 Sind-bed SF type inpatient days applicable to title XVII only (including private room days) 0 0.0 Sind-bed SF type inpatient days applicable to title XVII only (including private room days) 0 0.10 Sind-bed SF type inpatient days applicable to title XVII only (including private room days) 0 11 0.0 Sind-bed SF type inpatient days applicable to title XVII only (including private room days) 0 12 0.0 Sind-bed SF type inp						
do not complete this line. 6.364 4.4 Semi-private room days (sectualing swing-bed and observation bed days) 6.364 4.4 Complete this sum of bed SWE type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 1 ine) 6.364 4.4 Comporting period 0.01 10.1						
0.00 Semi-private room days (excluding swing-bed and observation bed days) 6.364 4.4 0 0.10 Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period 0 6.1 0.10 Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 0 10 0.00 Swing-bed SK type inpatient days applicable to titles VII in VII (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 10 0.01 Swing-bed K type inpatient days applicable to titles V or XIX only (including private room days) 0 11 0.02 Swing-bed K type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 12 0.03 Swing-bed K type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 12 0.01 Swing-bed K type inpatient days applicable to services after D			ys). If you have only pr	ivate room days,	0	3.0
000 Total issuing-bed SNE "type inpatient days" (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this 1 ins). 0 0 000 Total issuing-bed SNE type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this 1 ins). 0 0 000 Total issuing-bed NE type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this 1 ins). 0 0 000 Total issuing-bed NE type inpatient days applicable to the Program (excluding sing-bed and type inpatient days applicable to the Program (excluding private room days). 0 10 000 Saing-bed NE type inpatient days applicable to title XVII only (including private room days). 0 10 000 Saing-bed NE type inpatient days applicable to title XVII only (including private room days). 0 12 000 Saing-bed NE type inpatient days applicable to title XVII and y (including private room days). 0 12 000 Saing-bed NE type inpatient days applicable to title XVII and y (including sing-bed days). 0 12 000 Saing-bed NE type inpatient days applicable to services through becember 31 of the cost. 0 0 000 Narrey days (title V or XIX only) 0 14 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
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0.00 Initial swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost 0 7.0 0.01 Initial swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.1 0.02 Initial swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.1 0.03 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 0 10.4 0.03 Swing-bed SWF type inpatient days applicable to tille XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 11.4 0.03 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 0 13.4 0.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 0 14.4 0.05 Total minesery days (tille V or XIX only) 0 15.4 0.05 Model Carls Proceed SNF services applicable to services after December 31 of the cost reporting period 0.00 17.0 0.00 Indicar Proceed SNF Services applicable to services after December 31 of the cost reporting period 0.00 16.4 0.00 M		5 51 1 5 (51	om days) through becembe	er 31 OF the Cost	0	5.0
Teporting period (if calendar year, enter 0 on this line) 7.1 Total sing-bed K Type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.1 0.00 Swing-bed SK Type inpatient days applicable to the Program (excluding swing-bed and reporting period (if calendar year, enter 0 on this line) 9.1 0.00 Swing-bed SK Type inpatient days applicable to the Program (excluding swing-bed and reporting period (if calendar year, enter 0 on this line) 0.1 1.00 Swing-bed SK Type inpatient days applicable to the Vor XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0.1 2.00 Swing-bed KF Type inpatient days applicable to titles V or XIX only (including private room days) 0.1 11.4 3.00 Swing-bed KF Type inpatient days applicable to titles V or XIX only (including private room days) 0.1 13.4 3.00 Swing-bed KF Type inpatient days applicable to the Program (excluding swing-bed days) 0.1 14.5 3.00 Swing-bed KF Type inpatient days applicable to services after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0.4 3.00 Swing-bed KF Type inpatient days applicable to services after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 0.4 3.00 Swing-bed KF Services applicable to services after December 31 of the cost reporting period (in calendar year, enter 0 on this line		Ning-bed SNE type inpatient days (including private roo	m davs) after December	31 of the cost	0	60
100 Total saving-bed Wit type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0			and a good and a second and a second and a second a secon	of of the cost	0	0.0
reporting period 0			n davs) through December	31 of the cost	0	7.0
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x line 18) 4.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 0 5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 0 6.00 Total swing-bed cost (see instructions) 0 26.0 7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5,444,692 27.0 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 0 26.0 29.0 29.0 8.00 General inpatient routine service charges (excluding swing-bed charges) 0 28.0 9.00 Private room charges (excluding swing-bed charges) 0 30.0 0.0000000 31.0 1.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.0 0.00 32.0 3.00 Average perivate room per diem charge (line 30 + line 4) 0.00 33.0 0.00 33.0 4.00 Average perivate room cost differential (line 34 x line 31) 0.00 34.0 0.00 34.0 5.00 Average perivate room cost differential (line 3 x line 35)		,	31 of the cost reportin	a period (line 6	0	23 0
44.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 0 24.0 5.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 0 0 6.00 Total swing-bed cost (see instructions) 0 0 7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5,444,692 7.00 General inpatient routine service charges (excluding swing-bed charges) 0 28.0 9.00 Private room charges (excluding swing-bed charges) 0 28.0 0.00 Semi-private room per diem charge (line 29 + line 3) 0.000000 31.0 3.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 32.0 3.00 Average per diem private room cost differential dj ustment (line 3 x line 35) 0.00 33.0 3.00 Average per diem private room cost differential dj ustment (line 3 x line 35) 0.00 33.0 3.00 Average per diem private room cost BEFORE PASS THROUGH COST ADJUSTMENTS 0.00 35.0 3.00 Average general inpatient routine service cost per diem (see instructions) 0.36.0 0.36.0 0.00			of the cost reportin	ig period (Trite o	0	20.0
7 x line 19) 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 0 6.00 Total swing-bed cost (see instructions) 0 6.00 Total swing-bed cost (see instructions) 0 7.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5,444,692 7.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 8.00 General inpatient routine service charges (excluding swing-bed charges) 0 9.00 Private room charges (excluding swing-bed charges) 0 0.00 Semi-private room charges (excluding swing-bed charges) 0 0 1.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 0 2.00 Average per diem private room cost differential (line 3 + line 31) 0.00 30.0 3.00 Average per diem private room cost differential (line 3 x line 31) 0.00 30.0 6.00 Private room cost differential dijustment (line 3 x line 35) 0 0 30.0 6.00 Private room cost differential adjustment (line 3 x line 35) 0 0 30.0			- 31 of the cost reporti	na period (line	0	24.0
x line 20)x6.00Total swing-bed cost (see instructions)07.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)07.00General inpatient routine service charges (excluding swing-bed and observation bed charges)08.00General inpatient routine service charges (excluding swing-bed charges)09.00Private room charges (excluding swing-bed charges)00.00Semi-private room charges (excluding swing-bed charges)00.00Semi-private room per diem charge (line 29 + line 3)0.0000003.00Average private room per diem charge (line 29 + line 3)0.0003.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.005.00Average per diem private room cost differential (line 3 x line 31)0.006.00Private room cost differential adjustment (line 3 x line 35)00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 444, 6927.00General inpatient routine service cost per diem (see instructions)0.008.00Private general inpatient routine service cost per diem (see instructions)0.30.08.00Adjusted general inpatient routine service cost per diem (see instructions)829.358.00Adjusted general inpatient routine service cost per diem (see instructions)829.359.00Program general inpatient routine service cost applicable to the Program (line 14 x line 35)00.00Medically necessary private room cost applicable to				5 1 2 2 2		
66.00Total swing-bed cost (see instructions)026.0General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)5,444,69227.0PRIVATE ROOM DIFFERENTIAL ADJUSTMENT028.080.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.09.00Private room charges (excluding swing-bed charges)029.00.00Semi-private room charges (excluding swing-bed charges)030.00.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.02.00Average private room per diem charge (line 30 + line 3)0.00000032.03.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.04.00Average per diem private room cost differential (line 34 x line 31)0.0035.05.00Private room cost differential djustment (line 3 x line 35)0.00035.06.00Pix unine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)36.07.00General inpatient routine service cost per diem (see instructions)0.30.08.00Adjusted general inpatient routine service cost per diem (see instructions)829.358.00Adjusted general inpatient routine service cost per diem (see instructions)829.358.00Adjusted general inpatient routine service cost per diem (see instructions)1,832,0349.00Program general inpatient routine service cost per diem (see instructions)1,832,03	25.00 Swing-b	ed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.0
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PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.0 8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 9.00 Private room charges (excluding swing-bed charges) 0 0.00 Semi-private room charges (excluding swing-bed charges) 0 0.00 Semi-private room charges (excluding swing-bed charges) 0 0.00 Semi-private room charges (excluding swing-bed charges) 0 0.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000131.0 2.00 Average private room per diem charge (line 29 + line 3) 0.0000031.0 3.00 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 0.000 4.00 Average per diem private room cost differential (line 34 x line 31) 0.000 6.00 Private room cost differential djustment (line 3 x line 35) 0 35.0 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 444, 692 37.0 27 minus line 36) 0 0 36.0 PART II - HOSPITAL AND SUBPROVIDERS ONLY 88.00 Adjusted general inpatient routine service cost per diem (see instructions) 829.35 38.0		5				
88.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.099.00Private room charges (excluding swing-bed charges)029.000.00Semi-private room charges (excluding swing-bed charges)030.010.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.02.00Average private room per diem charge (line 29 ÷ line 3)0.00032.03.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.04.00Average per diem private room cost differential (line 34 x line 31)0.0034.05.00Average per diem private room cost differential (line 3 x line 35)0.0035.06.00Private room cost differential adjustment (line 3 x line 35)0.3036.07.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 444, 69237.07.00PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY9.0038.09.00Program general inpatient routine service cost per diem (see instructions)829.358.00Adjusted general inpatient routine service cost (line 9 x line 38)1, 832, 0349.00Medically necessary private room cost applicable to the Program (line 14 x line 35)00.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			(line 21 minus line 26)		5, 444, 692	27.0
99.00Private room charges (excluding swing-bed charges)00.00Semi-private room charges (excluding swing-bed charges)00.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.0000002.00Average private room per diem charge (line 30 ÷ line 3)0.0000003.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0004.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.005.00Average per diem private room cost differential (line 3 x line 31)0.006.00Private room cost differential adjustment (line 3 x line 35)0.307.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 444, 69237.007.00PART 11 - HOSPI TAL AND SUBPROVI DERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS829.358.00Adjusted general inpatient routine service cost per diem (see instructions)829.359.00Program general inpatient routine service cost (line 9 x line 38)1, 832, 0349.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			d and abcomuction had ab		0	
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6.00 Private room cost differential adjustment (line 3 x line 35) 0 36.0 7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 5,444,692 37.0 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 829.35 38.0 9.00 Program general inpatient routine service cost (line 9 x line 38) 1,832,034 39.0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0	5		nus line 33)(see instruc	tions)		
7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 444, 692 27 minus line 36) 37.0 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.0 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 829.35 38.0 9.00 Program general inpatient routine service cost (line 9 x line 38) 1, 832, 034 39.0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0			ne 31)		0.00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost (line 9 x line 38) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 829.35 38.0 9.00 Program general inpatient routine service cost (line 9 x line 38) 1,832,034 39.0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0			and private room cost di	fferential (line	5, 444, 692	37.0
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS8.00Adjusted general inpatient routine service cost per diem (see instructions)829.359.00Program general inpatient routine service cost (line 9 x line 38)1,832,0340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0						1
8.00Adjusted general inpatient routine service cost per diem (see instructions)829.3538.09.00Program general inpatient routine service cost (line 9 x line 38)1,832,03439.00.00Medically necessary private room cost applicable to the Program (line 14 x line 35)00						-
9.00Program general inpatient routine service cost (line 9 x line 38)1,832,03439.00.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.0					000.05	1 20 0
0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0						
	U U		-			

WPUI	ATION OF INPATIENT OPERATING COST		Provider (eriod: rom 01/01/2016	Worksheet D-1	I
					0 12/31/2016	Date/Time Pre	
			Titl	e XVIII	Hospi tal	5/31/2017 9:4 PPS	11 a
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	sDiem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
00	NURSERY (title V & XIX only)	0		0.00) 42
~~	Intensive Care Type Inpatient Hospital Units						
00 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0		0.00		-	
00	BURN INTENSIVE CARE UNIT	0		0.00		-	
	SURGI CAL I NTENSI VE CARE UNI T	0		0.00		0	
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			9, 553, 796	48
00	Total Program inpatient costs (sum of lines 4	11 through 48)(see instructi	ons)		11, 385, 830	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	sorvicos (fro	wkst D sum	of Parts L and	207, 955	5 50
00	(111)		services (110	n wkst. D, Sum		207, 933	
00	Pass through costs applicable to Program inpa	atient ancillar	y services (f	rom Wkst. D, su	m of Parts II	390, 553	3 51
00	and IV) Total Program excludable cost (sum of lines {	50 and 51				598, 508	3 52
00	Total Program inpatient operating cost exclude		lated, non-ph	ysician anesthe	tist, and	10, 787, 322	
	medical education costs (line 49 minus line s		, p.,	,			
00	TARGET AMOUNT AND LIMIT COMPUTATION					~	,
00 00	Program discharges Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (line 56 minus l	ine 53)	0	
00 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting pariod	onding 1004	undated and com	nounded by the	0.00	
00	market basket	borting period	ending 1996,	updated and com	pounded by the	0.00	1 59
00	Lesser of lines 53/54 or 55 from prior year of					0.00	60
00	If line 53/54 is less than the lower of lines					0) 6'
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% or	the target		
00	Relief payment (see instructions)					0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of th	e cost reportin	a period (See	0	64
00	instructions) (title XVIII only)	through beec			g period (bee		
00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the	cost reporting	period (See	0	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	na costs (lina	64 nlus line	65)(titla XVIII	only) For	0	66
00	CAH (see instructions)		o4 prus rine		onry). Tor		
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost rep	orting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	a coste after D	acombor 21 of	the cost repor	ting pariod		40
00	(line 13 x line 20)		ecember 31 01	the cost repor	ting period	0	68
00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67 + lin	e 68)		0	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU						
00 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70
00	Program routine service cost (line 9 x line 3			-/			72
00	Medically necessary private room cost applica	U U	•	,			73
00 00	Total Program general inpatient routine servi	•			rt II colump		74
00	Capital-related cost allocated to inpatient r 26, line 45)	Service		NUL NSHEEL D, PA			/
00	Per diem capital-related costs (line 75 ÷ lin						76
00	Program capital -related costs (line 9 x line						7
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der recor	ds)			78
00	Total Program routine service costs for compa	• •		· ·	s line 79)		80
00	Inpatient routine service cost per diem limit	tation			·		8
00	Inpatient routine service cost limitation (li		· .				82
00 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		5)				83
00	Utilization review - physician compensation		ns)				85
00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					001	
00						201	87
00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			829.35	

Health Financial Systems LU	SKELETAL CENTER		In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	618, 059	5, 444, 692	0. 11351	6 166, 699	18, 923	90.00
91.00 Nursing School cost	0	5, 444, 692	0.00000	0 166, 699	0	91.00
92.00 Allied health cost	0	5, 444, 692	0.00000	0 166, 699	0	92.00
93.00 All other Medical Education	0	5, 444, 692	0.00000	0 166, 699	0	93.00

LUTHERAN	MUSCULOSKEI	_ETAL	CENT	ER	

Heal th	Financial Systems LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016		
		Title XIX	Hospi tal	5/31/2017 9:4 Cost	I alli
	Cost Center Description		nospi tui	0031	
	·			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	c oveluding newbern)		6, 565	1.00
2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			6, 565	2.00
3.00	Private room days (excluding swing-bed and observation bed day		rivate room davs.	0,000	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			6, 364	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)		ST OF the cost	0	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	~ 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December (31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	n swing_bed and	405	9,00
7.00	newborn days)		g sinnig bed and	100	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
	through December 31 of the cost reporting period (see instruc	<i>,</i>		_	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room davs)	0	12.00
12.00	through December 31 of the cost reporting period	ing (merdaring priva	te room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14.00 15.00
16.00	Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.00
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18.00
19,00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0, 00	19.00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	the cost	0.00	20.00
21 00	reporting period	-)		F 444 (00	21 00
21.00 22.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting period (line	5, 444, 692 0	21.00 22.00
22.00	5 x line 17)	er of the cost report	ting period (inite	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
	x line 18)			_	
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	n period (line 8	0	25.00
201.00	x line 20)		g por rou (r no o	J. J	20100
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 444, 692	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and abcomunition had a		0	
28.00 29.00	Private room charges (excluding swing-bed charges)	a and observation bed cr	larges)	0	28.00 29.00
30.00	Semi-private room charges (excluding swing bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		-+:>	0.00	
34.00 35.00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	, ,	strons)	0.00 0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5, 444, 692	
	27 minus line 36)	· · · · · ·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			000.05	20 00
38.00 39.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	instructions)		829.35 335.887	
38.00 39.00 40.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	instructions) 38)		829. 35 335, 887 0	39.00

	<u> </u>	THERAN MUSCULOS	SKELETAL CE	NTER	2	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CC		Period: From 01/01/2016	Worksheet D-1	
						To 12/31/2016		
				T; +1	e XIX	Hospi tal	5/31/2017 9:4 Cost	1 am
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost		Days			(col. 3 x col.	
		1.00			col . 2)	4.00	4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	0	3.00	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units			0	0.00	<u> </u>	0	42.00
	INTENSIVE CARE UNIT	0		0				43.00
	CORONARY CARE UNIT	0		0				44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0				45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)	0		0	0.00		0	47.00
	Cost Center Description							
10.00							1.00	40.00
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				ns)		99, 712 435, 599	48.00 49.00
47.00	PASS THROUGH COST ADJUSTMENTS				1137		433, 377	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (1	from	Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	ry services	(fr	om Wkst. D, su	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)					0	52.00
	Total Program inpatient operating cost exclu	,	elated, non-	-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line	52)						
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						0	E4 00
	Program discharges Target amount per discharge						0 0.00	54.00 55.00
	Target amount (line 54 x line 55)						0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	arget amoun ⁻	t (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	opding 100	6 11	ndated and com	nounded by the	0 0.00	58.00 59.00
57.00	market basket	por tring period	ending 1990	0, u		pounded by the	0.00	57.00
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	60.00
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha						0	61.00
	amount (line 56), otherwise enter zero (see		is (Thes 5	+ ^	00), 01 1% 01	the target		
	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)				0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the	cost reportir	a period (See	0	64.00
	instructions)(title XVIII only)	-						
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of th	he c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus lin	ne 6	5)(title XVIII	only). For	0	66.00
	CAH (see instructions)							
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 3	31 o	f the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31	of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + l	line	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	5						70.00 71.00
72.00	Program routine service cost (line 9 x line		1110 70 . 11	i ne	2)			72.00
73.00	Medically necessary private room cost applic	0	•		ne 35)			73.00
74.00 75.00	Total Program general inpatient routine serv				larkchoot P Dr	st II column		74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	Tout the service		UII W	ULKSHEEL D, Pa	int II, corumn		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76.00
77.00	Program capital-related costs (line 9 x line							77.00
78.00 79.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovider re	cord	c)			78.00 79.00
80.00	Total Program routine service costs for comp					ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limi							81.00
82.00	Inpatient routine service cost limitation (I		· .					82. 00 83. 00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)					83.00 84.00
	Utilization review - physician compensation		ons)					85.00
	Total Program inpatient operating costs (sum	of lines 83 th						86. 00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions						201	87.00
87.00 88.00	Adjusted general inpatient routine cost per		line 2)				829.35	87.00 88.00
	Observation bed cost (line 87 x line 88) (se						166, 699	

Health Financial Systems LL	JTHERAN MUSCULOS	HERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1		
				To 12/31/2016			
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	618, 059	5, 444, 692	0. 11351	6 166, 699	18, 923	90.00	
91.00 Nursing School cost	0	5, 444, 692	0.00000	0 166, 699	0	91.00	
92.00 Allied health cost	0	5, 444, 692	0.00000	0 166, 699	0	92.00	
93.00 All other Medical Education	0	5, 444, 692	0.00000	0 166, 699	0	93.00	

	cial Systems LUTHERAN MUSCL CILLARY SERVICE COST APPORTIONMENT	JLOSKELETAL CENTE Provider C	CN: 15-0168	Peri od:	u of Form CMS- Worksheet D-3	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
		Ti †l e	e XVIII	Hospi tal	PPS	ı di
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
			_	Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS		1	3, 400, 453		30
	INTENSI VE CARE UNI T			3, 400, 433		31
	CORONARY CARE UNIT			0		32
	BURN INTENSIVE CARE UNIT			0		33
	SURGI CAL I NTENSI VE CARE UNI T			0		34
	SUBPROVIDER - IPF			0		40
	SUBPROVIDER - IRF			0		41
	NURSERY					43
ANCI LL	ARY SERVICE COST CENTERS		1			
. 00 05000	OPERATING ROOM		0.0800		2, 723, 928	50
	RECOVERY ROOM		0. 0266		0	
	DELIVERY ROOM & LABOR ROOM		0.0000		0	
	ANESTHESI OLOGY		0.0000		0	
	RADI OLOGY-DI AGNOSTI C		0. 0558		78, 546	
	ULTRA SOUND		0. 0398		0	
	RADI OLOGY-THERAPEUTI C		0.0000		0	
	RADI OI SOTOPE		0.0778		0	
	CT SCAN		0.6471		0	
	MAGNETIC RESONANCE I MAGING (MRI)		1. 2587		0	
	CARDIAC CATHETERIZATION		0.0000		0	
	LABORATORY		0.0910		132, 922	
1 1	BLOOD LABORATORY		0.0000		0	
	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
	BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
	INTRAVENOUS THERAPY		0.0000		0	
	RESPI RATORY THERAPY		0. 0486		7, 517	
	PHYSI CAL THERAPY		0. 3025			
	OCCUPATIONAL THERAPY		0.0000		0	
	SPEECH PATHOLOGY		0.0000		0	
	ELECTROCARDI OLOGY		0.0621		8, 830	
	ELECTROENCEPHALOGRAPHY		0.0000		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0470		219, 228	7
. 00 07200	IMPL. DEV. CHARGED TO PATIENTS		0. 1363	11 39, 151, 182	5, 336, 737	72
. 00 07300	DRUGS CHARGED TO PATIENTS		0. 0747	47 6, 271, 481	468, 774	7:
. 00 07400	RENAL DI ALYSI S		0.0016	56 11, 868	20	74
	ASC (NON-DISTINCT PART)		0.0000	00 0	0	75
	TIENT SERVICE COST CENTERS					
	RURAL HEALTH CLINIC		0.0000		0	
	FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
			0.0000		0	
	EMERGENCY		0.0000		0	
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS		0.8835	85 22, 852	20, 192	92
	HOME PROGRAM DIALYSIS		0.0000	0 00	0	94
	AMBULANCE SERVICES		0.0000	00	0	92
	DURABLE MEDICAL EQUIP-RENTED		0.0000	00	0	
	DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
	OTHER REIMBURSABLE COSTS		0.0000		0	
	Total (sum of lines 50-94 and 96-98)		0.0000	89, 148, 816	9, 553, 796	
	Less PBP Clinic Laboratory Services-Program only cl	narges (line 61)		07, 140, 010 A	7, 555, 790	200
	Less i bi offine Laboratory services i ogram offiy e		1	0		1201

NPATI EN	i nanci al Systems LUTHERAN MUSCULOSKEI IT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider C	CN: 15-0168	Peri od:	Worksheet D-3	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:4	
		Ti tl	e XIX	Hospi tal	Cost	i un
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges	U	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
LN	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	3000 ADULTS & PEDIATRICS			33, 787		30.
	3100 I NTENSI VE CARE UNI T			0		31.
	3200 CORONARY CARE UNI T			0		32
3.00 03	3300 BURN INTENSIVE CARE UNIT			0		33
4.00 03	3400 SURGI CAL I NTENSI VE CARE UNI T			0		34
0. 00 04	4000 SUBPROVI DER – I PF			0		40
	4100 SUBPROVI DER – I RF			0		41
	4300 NURSERY			0		43
	NCI LLARY SERVI CE COST CENTERS		0.0000	401 000	00,000	1 - 0
	5000 OPERATING ROOM		0.0800		39, 380	
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM		0.0266		0	
	5300 ANESTHESI OLOGY		0.0000		0	
	5300 ANESTRESTOLOGY 5400 RADI OLOGY-DI AGNOSTI C		0.0000		985	
	3630 ULTRA SOUND		0.0398		983	
	5500 RADI OLOGY-THERAPEUTI C		0.0000		0	
	5600 RADI OLOGI - MERAFLOTI C		0.0000		0	
	5700 CT SCAN		0.6471		0	
	5800 MAGNETIC RESONANCE I MAGING (MRI)		1. 2587		0	
	5900 CARDI AC CATHETERI ZATI ON		0.0000		0	
	6000 LABORATORY		0.0910		2,089	
	6001 BLOOD LABORATORY		0.0000		0	
1	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	62
3.00 08	6300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00 0	0	63
1.00 06	6400 I NTRAVENOUS THERAPY		0.0000	00 0	0	64
5.00 06	6500 RESPI RATORY THERAPY		0. 0486	21 0	0	65
	6600 PHYSI CAL THERAPY		0. 3025	35 13, 569	4, 105	66
7.00 06	6700 OCCUPATI ONAL THERAPY		0.0000	00 0	0	67
	6800 SPEECH PATHOLOGY		0.0000		0	
	6900 ELECTROCARDI OLOGY		0.0621		24	
	7000 ELECTROENCEPHALOGRAPHY		0.0000		0	
1	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.0470		2, 200	
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 1363		46, 548	
	7300 DRUGS CHARGED TO PATIENTS		0.0747		4, 381	
	7400 RENAL DIALYSIS		0.0016		0	
	7500 ASC (NON-DISTINCT PART) JTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	/ / 3
	8800 RURAL HEALTH CLINIC		0.0000	00 0	0	88
	8900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
	9000 CLINIC		0.0000		0	
	9100 EMERGENCY		0.0000			91
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8835			
	THER REIMBURSABLE COST CENTERS					
4.00 09	9400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94
5.00 09	9500 AMBULANCE SERVI CES					95
5.00 09	9600 DURABLE MEDI CAL EQUI P-RENTED		0.0000	00 0	0	96
	9700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	1
	9850 OTHER REI MBURSABLE COSTS		0.0000		0	
00.00	Total (sum of lines 50-94 and 96-98)			993, 329	99, 712	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
02.00	Net Charges (line 200 minus line 201)		1	993, 329		202

ALCUL	Financial Systems LUTHERAN MUSCULOSKE ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/31/2017 9:4	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (See	0 8, 412, 187	1.00 1.0 ²
. 02	DRG amounts other than outlier payments for discharges occurr	0.1		3, 210, 324	1.02
	instructions)	0			
. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	0		0	1.03
. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.04
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			2, 017 0	2.00 2.0
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.0
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	0 38.45	3.00 4.00
	Indirect Medical Education Adjustment				
. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0.00	6.00
. 00	MMA Section 422 reduction amount to the IME cap as specified			0.00	7.00
. 01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instructio	ns.		0.00	7.0'
. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
. 01	The amount of increase if the hospital was awarded FTE cap slithe cost report straddles July 1, 2011, see instructions.	ots under section 5503 o	of the ACA. If	0.00	8. 0 [.]
. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospital	0.00	8. 0
. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin- instructions)	es (8, 8,01 and 8,02)	see	0.00	9. 00
0.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	ds		10.00
1.00 2.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	11. 0 12. 0
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	14.0
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15.0
6.00	Adjustment for residents in initial years of the program				16.0
7.00	Adjustment for residents displaced by program or hospital clo	sure			17.0
8.00	Adjusted rolling average FTE count	、 、			18.0
9.00 0.00	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)).		0.000000 0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0.000000	
2.00	IME payment adjustment - Managed Care (see instructions)			0	
3. 00	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE resid		Sec. 412 105	0.00	23. 0
4.00	(f)(1)(iv)(C).				
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	e 24 (see	0.00 0.00	
6.00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 0
7.00	IME payments adjustment factor. (see instructions)			0.00000	27.0
8.00	IME add-on adjustment amount (see instructions)			0	28.0
8. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.0
9. 00 9. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 0 29. 0
7. UI	Disproportionate Share Adjustment	1 <i>)</i>		0	29.0
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient davs (see instruc	ctions)	1.89	30. 0
1.00	Percentage of Medicaid patient days (see instructions)			0.00	
2.00	Sum of lines 30 and 31				32.0
3.00	Allowable disproportionate share percentage (see instructions)			33.0
	Disproportionate share adjustment (see instructions)			0	34.0

ALCUL	Financial Systems LUTHERAN MUSCULO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Period:	u of Form CMS-2 Worksheet E	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
		Title XVIII	Hospi tal	5/31/2017 9:4 PPS	1 am
			Prior to 10/1		
			1. 00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		6, 406, 145, 534		
5.01	Factor 3 (see instructions)		0.000005795	0.00006327	
5.02	Hospital uncompensated care payment (If line 34 is zero, e	enter zero on this line)	0	0	35.
- 02	(see instructions)			0	0.5
5.03 6.00	Pro rata share of the hospital uncompensated care payment a		0	0	35. 36.
0.00	Total uncompensated care (sum of columns 1 and 2 on line 39 Additional payment for high percentage of ESRD beneficiary				30.
0. 00	Total Medicare discharges on Worksheet S-3, Part I excludin		0		40.
0.00	652, 682, 683, 684 and 685 (see instructions)	ng di scharges i di mo-bidos	0		40.
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41.
	instructions)	,,,,,	Ū.		
1. 01	Total ESRD Medicare covered and paid discharges excluding I	MS-DRGs 652, 682, 683, 684	0		41.
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qua	alify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		43.
	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44.
	days)				
5.00	Average weekly cost for dialysis treatments (see instruction		0.00		45.
6.00	Total additional payment (line 45 times line 44 times line	41.01)	0		46
7.00	Subtotal (see instructions)		11, 624, 528		47
8. 00	Hospital specific payments (to be completed by SCH and MDH,	, smail rurai nospitais	0		48
	only. (see instructions)			Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction	ons)		11, 624, 528	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			925, 882	
1.00	Exception payment for inpatient program capital (Wkst. L, I			0	
2.00	Direct graduate medical education payment (from Wkst. E-4,			0	52.
3.00	Nursing and Allied Health Managed Care payment			0	53.
4.00	Special add-on payments for new technologies			0	54.
4.01	Islet isolation add-on payment			0	54
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55
6.00	Cost of physicians' services in a teaching hospital (see in	ntructions)		0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt.		nrough 35).	0	
8.00	Ancillary service other pass through costs from Wkst. D, P	t. IV, col. 11 line 200)		0	
9.00	Total (sum of amounts on lines 49 through 58)			12, 550, 410	
0.00	Primary payer payments			53, 426	
1.00	Total amount payable for program beneficiaries (line 59 min	nus iine 60)		12, 496, 984	
2.00	Deductibles billed to program beneficiaries			1, 096, 004	
3.00	Coinsurance billed to program beneficiaries			0 24 510	
	Allowable bad debts (see instructions)			34, 510	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		22, 432 4, 014	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	nstructions)		4,014	
8.00	Credi ts received from manufacturers for replaced devices for	or applicable to MS-DRGs (se	e instructions)	11, 423, 412	
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	
0.50	RURAL DEMONSTRATI ON PROJECT			0	
	SCH or MDH volume decrease adjustment			0	
J. XX	Pioneer ACO demonstration payment adjustment amount (see in	nstructions)		0	
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0. 89		•		0	
0. 89 0. 90					
0. 89 0. 90 0. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
0.89 0.90 0.91 0.92					70
0. 89 0. 90 0. 91 0. 92 0. 93	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70 70

Health Financial Systems LUTHERAN MUSCULOSKE				u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0168	Period: From 01/01/2016	Worksheet E Part A	
			To 12/31/2016	Date/Time Pre	pared:
				5/31/2017 9:4	1 am
	Title	XVIII	Hospi tal	PPS	
		FFY	′ (уууу)	Amount	
			0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.96
the corresponding federal year for the period prior to 10/1)			0	0	70 07
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98 Low Volume Payment-3				0	70, 98
70. 99 HAC adjustment amount (see instructions)				0	70.99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			11, 524, 595	
71. 01 Sequestration adjustment (see instructions)	0, 4,0)			230, 492	
72.00 Interim payments				11, 272, 119	
73.00 Tentative settlement (for contractor use only)				0	
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72	, and 73)			21, 984	
75.00 Protested amounts (nonallowable cost report items) in accorda				194, 844	•
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruc				0	93.00
94.00 The rate used to calculate the time value of money (see instr				0.00	
95.00 Time value of money for operating expenses (see instructions)				0	95.00
96.00 Time value of money for capital related expenses (see instruc	tions)		D: 10/4	0	96.00
			Prior to 10/1 1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payment			9	0	100.00
101.00 HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101.00
	s)		0		102.00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction				-	4
102.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	-/				
	-,		0.0000	0. 0000	103.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Period: From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDI CAL AND OTHER HEALTH SERVI CES			1.00	
00	Medical and other services (see instructions)			2, 969	1
00	Medical and other services reimbursed under OPPS (see instr	ructions)		2, 217, 672	2
00	PPS payments			3, 151, 376	3
00 00	Outlier payment (see instructions)	ructions)		12, 251 0. 000	45
00	Enter the hospital specific payment to cost ratio (see inst Line 2 times line 5			0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	8
00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 13, line 200		0	9
. 00	Organ acquisitions			0	10
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			2, 969	11
	Reasonable charges				
. 00	Ancillary service charges			39, 724	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	13
. 00	Total reasonable charges (sum of lines 12 and 13)			39, 724	14
. 00	Customary charges Aggregate amount actually collected from patients liable fo	or navment for services on	a charge basis	0	15
	Amounts that would have been realized from patients liable			0	16
	had such payment been made in accordance with 42 CFR §413.1		a onargobaoro	J. J	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			39, 724	
. 00	Excess of customary charges over reasonable cost (complete instructions)	only if line 18 exceeds li	ne 11) (see	36, 755	19
. 00	Excess of reasonable cost over customary charges (complete	only if line 11 exceeds li	ne 18) (see	0	20
	instructions)			-	
	Lesser of cost or charges (line 11 minus line 20) (for CAH	see instructions)		2, 969	
	Interns and residents (see instructions)	(atructions)		0	22
	Cost of physicians' services in a teaching hospital (see in Total prospective payment (sum of lines 3, 4, 8 and 9)	istructions)		3, 163, 627	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			071007027	-
	Deductibles and coinsurance (for CAH, see instructions)			11	
	Deductibles and Coinsurance relating to amount on line 24 (618, 839	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26 instructions)	b) plus the sum of lines 2.	2 and 23] (see	2, 547, 746	27
. 00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 3			0	29
	Subtotal (sum of lines 27 through 29)			2, 547, 746	
	Primary payer payments			0	31
. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SER	WICES)		2, 547, 746	32
. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
	Allowable bad debts (see instructions)			72, 631	34
	Adjusted reimbursable bad debts (see instructions)			47, 210	
	Allowable bad debts for dual eligible beneficiaries (see in	istructions)		55, 366	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 594, 956 706	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			,00	39
	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	39
. 98	Partial or full credits received from manufacturers for rep	laced devices (see instru	ctions)	0	39
. 99				0	39
00	Subtotal (see instructions)			2, 594, 250	
. 01 . 00	Sequestration adjustment (see instructions) Interim payments			51, 885 2, 495, 474	
	Tentative settlement (for contractors use only)			2, 473, 474	42
. 00	Balance due provider/program (see instructions)			46, 891	
. 00	Protested amounts (nonallowable cost report items) in accor	dance with CMS Pub. 15-2,	chapter 1,	0	44
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			0	90
	Outlier reconciliation adjustment amount (see instructions	5)		0	91
	The rate used to calculate the Time Value of Money			0.00	92
	Time Value of Money (see instructions)			0	93

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0168	Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		11, 272, 1 ⁻	19 0	2, 495, 474 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	0		0 0	0	3. 01
3. 02		0		0 0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Drovidor to Drogram			0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM	0		0 0	0	3.50
3.51		Ŭ		0	0	3.51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11, 272, 1	19	2, 495, 474	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.92
0. 77	5. 50-5. 98)			Ĭ		3. 21
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
5. 01	SETTLEMENT TO PROVIDER		21, 98	34	46, 891	6. O´
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		11, 294, 10		2, 542, 365	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems LUTHERAN MUSCULOS	KELETAL CENTER	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0168	Period:	Worksheet E-1		
			From 01/01/2016 To 12/31/2016		pared:	
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO		. 14	2, 832	1.00	
	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00 3.00						
3.00 4.00						
4.00 5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	0-12		6, 364 486, 303, 088	4.00 5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		637, 508		
7.00	CAH only - The reasonable cost incurred for the purchase of		Wkst S-2 Pt I	0007,0000	7.00	
	line 168	contra a mar toomion ogy		0		
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00	
9.00	Sequestration adjustment amount (see instructions)			0	9.00	
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)	0	32.00	

ALCUI	n Financial Systems LUTHERAN MUSC LATION OF REIMBURSEMENT SETTLEMENT	ULOSKELETAL CENTER Provider CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			0	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)		0	3.
. 00	Outlier Payments			0	4.
. 00	Unweighted intern and resident FTE count in the most re- to November 15, 2004 (see instructions)		0 1	0.00	5.
. 01	Cap increases for the unweighted intern and resident FT	E count for residents that we	re displaced by	0.00	5.
	program or hospital closure, that would not be counted		tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FT	Es in the new program growth p	period of a "new	0.00	7.
~~	teaching program" (see instructions)			0.00	
. 00	Current year's unweighted I&R FTE count for residents w	ithin the new program growth p	period of a "new	0.00	8.
. 00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	9.
0.00			,	17. 387978	
1.00	5 5 7			0.000000	
2.00				0.000000	
3.00	5 5			0	
4.00	5	struction)		0	
5.00	5 5				15
5.00	5 1 , ,	e instructions)		0	
7.00				0	
8. 00	Primary payer payments			0	18
9.00	Subtotal (line 17 less line 18).			0	19.
0. 00	Deducti bl es			0	20
1. 00	Subtotal (line 19 minus line 20)			0	21
2.00	Coinsurance			0	22
3.00	Subtotal (line 21 minus line 22)			0	23
4.00		services) (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	
6.00	5	e instructions)		0	
7.00				0	
8.00	5	E-4, line 49)		0	28
9.00				0	29
0.00	1 5			0	30
1.00		uctions)		0	31 31
1.50 1.99		uctions)		0	
2.00	5			0	
2.00				0	
3.00				11, 272, 119	
4.00				0	
5.00	· · · · · · · · · · · · · · · · · · ·	. 33. and 34)		-11, 272, 119	
6. 00			chapter 1,		36.
	TO BE COMPLETED BY CONTRACTOR				
0. 00				0	50
1.00	5				51.
2.00	3			0.00	
	Time Value of Money (see instructions)				53.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od:	Worksheet E-3	2552
			From 01/01/2016 To 12/31/2016	Part VII	pare
		Title XIX	Hospi tal	Cost	i aiii
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		1		
00	Inpatient hospital/SNF/NF services		435, 599	0/ 007	1.
00	Medical and other services			86, 207	2.
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		435, 599	86, 207	3. 4.
00	Inpatient primary payer payments		433, 377	00,207	5.
00	Outpatient primary payer payments		0	0	6.
00	Subtotal (line 4 less sum of lines 5 and 6)		435, 599	86, 207	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		0		8.
00	Ancillary service charges		993, 329	927, 416	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		002,220	007 414	11
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		993, 329	927, 416	12
. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	1 13
. 00	basi s	Services on a charge	0	Ŭ	.0.
. 00	Amounts that would have been realized from patients liable for	r payment for services o	on 0	0	14
	a charge basis had such payment been made in accordance with				
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	15
. 00	Total customary charges (see instructions)		993, 329	927, 416	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	557, 730	841, 209	17
00	line 4) (see instructions)	vifling 4 avagada li		0	10
. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y IT IT He 4 exceeds IT	ne 0	0	18
. 00	Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line	-	435, 599	86, 207	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	*			
. 00	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	_	25
	Routine and Ancillary service other pass through costs		0	0	26
. 00 . 00	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		435, 599	0 86, 207	28
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		433, 377	00, 207	27
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	435, 599	86, 207	
. 00	Deducti bl es		0	0	
. 00	Coinsurance		0	0	33
. 00	Allowable bad debts (see instructions)		0	0	34
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	435, 599	86, 207	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
. 00	Subtotal (line 36 ± line 37)		435, 599	86, 207	
. 00	Direct graduate medical education payments (from Wkst. E-4)		435 500	04 207	39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		435, 599	86, 207	
. 00	Interim payments Balance due provider/program (line 40 minus line 41)		435, 599	0 86, 207	41 42
	Protested amounts (nonallowable cost report items) in accordar	ace with CMS Pub 15 2	435, 599	86, 207	42
3.00					

ALANCE	inancial Systems LUTHERAN MUSCULOS SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provider C	CN: 15-0168	Period: From 01/01/2016	u of Form CMS-: Worksheet G	
nia-typ niy)	se accounting records, comprete the General Fund corumn			To 12/31/2016	Date/Time Pre 5/31/2017 9:4	pare 1 an
		General Fund	Specific Purpose Fund		Plant Fund	
C	URRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	-307, 248		0 0	0	1 1
	emporary investments	0		0 0	0	2
00 N	lotes recei vabl e	0		0 0	0	3
00 A	accounts receivable	19, 845, 948		0 0	0	4
00 0)ther receivable	0		0 0	0	5
	Allowances for uncollectible notes and accounts receivable	-2, 980, 126		0 0	0	
	nventory	1, 721, 883		0 0	0	
	Prepaid expenses	295, 740		0 0	0	8
	Other current assets	48, 139		0 0 0 0	0	10
	Due from other funds Total current assets (sum of lines 1-10)	18, 624, 336		0 0	0	10
	IXED ASSETS	10, 024, 330			0	1''
_	and	0		0 0	0	1 12
	and improvements	26, 765		0 0	0	
	Accumulated depreciation	-10, 706		0 0	0	14
	Buildings	11, 326		0 0	0	15
. 00 A	Accumulated depreciation	-2, 220		0 0	0	16
.00 L	easehold improvements	1, 343, 749		0 0	0	17
. 00 A	Accumulated depreciation	-202, 307		0 0	0	18
	ixed equipment	798, 915		0 0	0	19
	Accumulated depreciation	-172, 632		0 0	0	20
	Automobiles and trucks	28, 303		0 0	0	21
	Accumulated depreciation	-18, 063		0 0	0	22
	lajor movable equipment	9, 140, 843		0 0	0	23
	Accumulated depreciation	-6, 193, 593		0 0 0 0	0	24
1	linor equipment depreciable	1, 461, 014		0 0	0	25
	Accumulated depreciation HT designated Assets	-1, 114, 298		0 0	0	27
	Accumulated depreciation			0 0	0	
	li nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	5, 097, 096		0 0	0	
	THER ASSETS		1	-, -,	-	
	nvestments	0		0 0	0	31
2. 00 D	Deposits on Leases	0		0 0	0	32
3. OO D	Due from owners/officers	0		0 0	0	33
1.00 0	Other assets	1, 275, 382		0 0	0	34
5.00 T	otal other assets (sum of lines 31-34)	1, 275, 382		0 0	0	35
	otal assets (sum of lines 11, 30, and 35)	24, 996, 814		0 0	0	36
	URRENT LI ABI LI TI ES		1			
	ccounts payable	4, 793, 785		0 0	0	37
	alaries, wages, and fees payable	1, 389, 772		0 0	0	
	Payroll taxes payable	118, 886		0 0	0	
	lotes and Loans payable (short term)	50, 001		0 0	0	
1	Deferred income Accelerated payments	0		0	0	41
	Due to other funds	-247, 748, 358		0 0	0	
1	Other current liabilities	520, 160		0 0	0	
	otal current liabilities (sum of lines 37 thru 44)	-240, 875, 754		0 0	0	
	ONG TERM LIABILITIES	210/0/0/101		<u> </u>		
	lortgage payable	0		0 0	0	1 46
7. OO N	lotes payabl e	76, 388		o o	0	47
	Insecured Loans	0		0 0	0	48
9.00 0)ther long term liabilities	38, 363, 135		0 0	0	49
. 00 T	otal long term liabilities (sum of lines 46 thru 49)	38, 439, 523		0 0	0	50
	otal liabilities (sum of lines 45 and 50)	-202, 436, 231		0 0	0	51
	API TAL ACCOUNTS					
	General fund balance	227, 433, 045				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	0	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion otal fund balances (sum of lines 52 thru 58)	227, 433, 045		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	227, 433, 045		0 0	0	
		L 27,770,014	1	U U	0	1 00

	Financial Systems LU ENT OF CHANGES IN FUND BALANCES	ITHERAN MUSCULOS	Provider CC		Do	ri od:	u of Form CMS- Worksheet G-1	
STATEN	ENT OF CHANGES IN FOND DALANCES			JN. 13-0106		om 01/01/2016		pared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3, 00		4,00	5.00	
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	1.00	197, 216, 894 30, 216, 151			4.00	3.00	1.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	227, 433, 045		0	0	0	3.00
4.00 5.00 6.00	Additions (credit adjustments) (specify)	0			0		0	5.00
7.00		0			0		0	7.00
8.00 9.00		0			0		0	
10. 00 11. 00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		0 227, 433, 045			0 0		10.00 11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0 0		0	13.00
14. 00 15. 00		0			0 0		0	15.00
16. 00 17. 00		0			0 0		0	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		0 227, 433, 045			0 0		18.00 19.00
	sheet (line 11 minus line 18)	Endowment Fund	Pl ant	Fund				
		6.00	7.00	8.00				
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			3.00 4.00
5.00 6.00			0					5.00 6.00
7.00 8.00			0					7.00
9.00 10.00 11.00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)	0	0		0			9.00 10.00 11.00
12.00 13.00 14.00 15.00	Deductions (debit adjustments) (specify)		0 0 0 0					12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17)	0	0 0		0			16.00 17.00 18.00 19.00
	Fund balance at end of period per balance	1 0			0			1 19 00

ATEM		Provider CC	N: 15-0168	Period: From 01/01/201 To 12/31/201		epare
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					_
	General Inpatient Routine Services					
00	Hospi tal		10, 670, 3	70	10, 670, 370	
0C	SUBPROVIDER – IPF			0	0	
00	SUBPROVIDER – IRF			0	0	
00	SUBPROVIDER					4
00	Swing bed - SNF			0	0	
00	Swing bed - NF			0	0) 6
00	SKILLED NURSING FACILITY			0	0) 7
00	NURSING FACILITY			0	0) 8
00	OTHER LONG TERM CARE			0	0) 9
00	Total general inpatient care services (sum of lines 1-9)		10, 670, 3	70	10, 670, 370) 10
	Intensive Care Type Inpatient Hospital Services					
00	INTENSIVE CARE UNIT			0	C	11
00	CORONARY CARE UNI T			0	0) 12
00	BURN INTENSIVE CARE UNIT			0	0) 13
00	SURGI CAL I NTENSI VE CARE UNI T			0	0) 14
00	OTHER SPECIAL CARE (SPECIFY)					15
00	Total intensive care type inpatient hospital services (sum of I	i nes		0	0) 16
	11-15)					
00	Total inpatient routine care services (sum of lines 10 and 16)		10, 670, 3	70	10, 670, 370) 17
00	Ancillary services		263, 202, 23	37	0 263, 202, 237	18
00	Outpatient services			0 212, 430, 48	212, 430, 481	19
00	RURAL HEALTH CLINIC			0	0 0) 20
00	FEDERALLY QUALIFIED HEALTH CENTER			0	o	21
00	HOME HEALTH AGENCY				o) 22
00	AMBULANCE SERVICES			0	o) 23
. 00	СМНС				0 0	24
10	CORF			0	o	24
00	AMBULATORY SURGICAL CENTER (D. P.)			0	0 0	25
00	HOSPI CE			0	0 0	
00	OTHER (SPECIFY)			0	o	27
00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	273, 872, 60	212, 430, 48	486, 303, 088	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
00	Operating expenses (per Wkst. A, column 3, line 200)			79, 263, 65	54	29
00	ADD (SPECIFY)			0		30
00				0		31
00				0		32
00				0		33
00				0		34
00				0		35
00	Total additions (sum of lines 30-35)				0	36
00	DEDUCT (SPECI FY)			0		37
00				0		38
00				0		39
00				0		40
00				0		41
00	Total deductions (sum of lines 37-41)				0	42
00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		79, 263, 65	54	43
	to Wkst. G-3, line 4)					

Heal th	Financial Systems LUTHERAN MUSCULOSKE	ELETAL CENTER	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0168	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	hared
			10 12/31/2010	5/31/2017 9:4	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		486, 303, 088	1.00
2.00	Less contractual allowances and discounts on patients' accoun	its		376, 929, 023	2.00
3.00	Net patient revenues (line 1 minus line 2)			109, 374, 065	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		79, 263, 654	4.00
5.00	Net income from service to patients (line 3 minus line 4)			30, 110, 411	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
	OTHER INCOME			105, 740	
25.00	Total other income (sum of lines 6-24)			105, 740	
	Total (line 5 plus line 25)			30, 216, 151	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			30, 216, 151	29.00

	Financial Systems LUTHERAN MUSCULOSKELETAL CENT ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B Provider		F 01/0		ieu of Form (2552-10
CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B Provider	CCN:	5-0168	Period: From 01/01/20	Worksheet	1-5	
				To 12/31/20		Pre	bared:
					5/31/2017	9:4	1 am
				1.00	2.00		
4 00	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B						4 00
1.00	Total expenses related to care of program beneficiaries (see instruction	ons)			0	0	1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	>			0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instruction						2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions	5)				~	2.02
2.03	Total payment due (see instructions)				0	0	2.03
2.04	Outlier payments				0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)				0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)						3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)				_	_	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instruction	ns)			0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients				0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)						4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)						4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instruction	ıs)			0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries				0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance		bad deb	t	0	0	5.01
	recoveries for services rendered on or after 1/1/2011 but before 1/1/20						
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance		bad deb	t	0	0	5.02
	recoveries for services rendered on or after 1/1/2012 but before 1/1/20						
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance		f bad deb	t	0	0	5.03
	recoveries for services rendered on or after 1/1/2013 but before 1/1/20						
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt reco	overi es	s for		0	0	5.04
	services rendered on or after 1/1/2014					_	
5.05	Total bad debts (sum of line 5 through line 5.04)				0	0	5.05
6.00	Allowable bad debts (see instructions)				0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instruction				0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (s	see			0	0	8.00
	instructions)						
9.00	Program payment (see instructions)				0	0	9.00
	Unrecovered from Medicare (Part B) patients (see instructions)						10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Par	rt B, I	ine 33)		0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				-		
	Total allowable expenses (see instructions)				0		12.00
	Total composite costs (from Wkst. I-4, col. 2, line 11)				0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12	2)		0.0000	00		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0168	Period: From 01/01/2016		
			To 12/31/2016	Date/Time Prep 5/31/2017 9:4	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
00	Capital DRG other than outlier			925, 882	1.
01	Model 4 BPCI Capital DRG other than outlier			0	1.
00	Capital DRG outlier payments			0	2.
01	Model 4 BPCI Capital DRG outlier payments			0	2
00	Total inpatient days divided by number of days in the cost re	eporting period (see inst	ructions)	17.39	3
00	Number of interns & residents (see instructions)			0.00	4
00	Indirect medical education percentage (see instructions)			0.00	5
00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, columns 1 and	0	6
	1.01) (see instructions)				_
00	Percentage of SSI recipient patient days to Medicare Part A p	patient days (Worksheet E	, part A line	0.00	7
00	30) (see instructions) Percentage of Medicaid patient days to total days (see instru	uctions)		0.00	8
00	Sum of lines 7 and 8			0.00	
	Allowable disproportionate share percentage (see instructions	e)		0.00	
	Disproporti onate share adjustment (see instructions)	3)		0.00	
	Total prospective capital payments (see instructions)			925, 882	
				720,002	12
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
. 00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0	
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (see ir	-		0.00	
00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 x	line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	
00	Current year capital payments (from Part I, line 12, as appli			0	
	Current year comparison of capital minimum payment level to o			0	
. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	capital payment (trom pri	or year	0	11
	Net comparison of capital minimum payment level to capital pa	avments (line 10 plus lin	e 11)	0	12
	Current year exception payment (if line 12 is positive, enter		,	0	
				0	
3.00			orrowing period	0	1 14
3.00	Carryover of accumulated capital minimum payment level over of (if line 12 is penative enter the amount on this line)		. .		
3. 00 4. 00	(if line 12 is negative, enter the amount on this line)			0	15
3.00 4.00 5.00				0	