PART I - COST	REPORT STATUS		
Provi der	1. [X] Electronically filed cost report	Date: 5/31/2018	Time: 12:47 p
use only	2. [] Manually submitted cost report 3. [0] If this is an amended report enter the number of times the provide 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	r resubmitted this cost	report
Contractor use only	5. [1] Cost Report Status 6. Date Received:	10. NPR Date: 11. Contractor's Vendor Co 12.[0]If line 5, columr number of times r	n 1 is 4: Enter

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LUTHERAN MUSCULOSKELETAL CENTER (15-0168) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

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

(Si gned) Officer or Administrator of Provider(s)

VICE PRESIDENT - REVENUE MANAGEMENT

Title

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	·	1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	22, 737	50, 235	0	-3	1.00
2.00	Subprovider - IPF	o	0	0		0	2. 00
3.00	Subprovider - IRF	o	0	0		0	3. 00
5.00	Swing bed - SNF	o	0	0		0	5. 00
6.00	Swing bed - NF	o				0	6.00
7.00	SKILLED NURSING FACILITY	o	0	0		0	7. 00
8.00	NURSING FACILITY	o				0	8. 00
9.00	HOME HEALTH AGENCY I	o	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	o		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	o		0		0	11. 00
12.00	CMHC I	o		0		0	12. 00
200.00	Total	ol	22, 737	50, 235	0	-3	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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/31/2018 12:17 pm 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 7952 W. JEFFERSON BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46804 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 LUTHERAN 150168 23060 03/07/2008 Ν 0 3.00 1 MUSCULOSKELETAL CENTER Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22 02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. enter "Y" for yes or "N" <u>for no</u> In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days eligible unpai d paid days days unpai d 1.00 2.00 3. 00 4. 00 5. 00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3 out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 25 00 O 0 0 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

	Financial Systems LUTHERAN M AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Period: From 01/01/ To 12/31/	2017	Worksho Part I Date/Ti	eet S-2 me Pre	pared:
					Urban/Rur	al S		018 12: Geogr	
26. 00	Enter your standard geographic classification (not wa	ne) sta	atus at the her	inning of the	1.00	1	2. (00	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta	itus at the end	of the cost		1			27. 00
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cati on	in column 2.			C)		35. 00
	orrest in the sast raper tring parrou.				Begi nni r	ng:	Endi		
36. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for numbe	1.00		2.0	JU	36. 00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ds MDH status		C)		37. 00
	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37. 01
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
	enter subsequent dates.				Y/N		Υ/		
	Does this facility qualify for the inpatient hospital				1.00 e N		2. (39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re)? Enter in co equirements in	olumn 1 "Y" accordance					
	100 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						Y	•	40. 00
	, , , , , , , , , , , , , , , , , , ,	(V 1. 0	XVIII 0 2.00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital								
46. 00	Does this facility qualify and receive Capital paymen 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	ption f	or extraordina	nry circumsta	nces	N N	N N	N N	45. 00 46. 00
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment	api tal ?	P Enter "Y for	yes or "N"	for no.	N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in					N			56. 00
57. 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	"N" for no ir nis cost report	n column 1. I ³ ing period?	f column 1 Enter "Y"				57. 00
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	, if ap ursemer	pplicable. nt for physicia						58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes					N			59. 00
				NAHE 413.85 Y/N	Workshee Line #		Pass-Ti Qual i fi Cri teri	cation	
	Are you claiming nursing and allied health education			1. 00 N	2.00		3. (00	60.00
	any programs that meet the criteria under §413.85? (see ins	structions) IME	Direct GME	IME		Di rec	t GME	
		1. 00	2. 00	3. 00	4.00		5. (00	-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				30	0.00			61. 00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								61. 01
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61. 02
	ACA). (see instructions) Enter the base line FTE count for primary care								61. 03

		KELETAL CENTER			eu of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der C	CN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017		pared:
	Y/N	I ME	Direct GME	IME	Direct GME	, p
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. 04
care or general surgery. (see instructions)						
	Program Name Program Code Unweighted I FTE Count				Unweighted Direct GME FTE Count	
	1.00		2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61. 10
of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	ı			0.00	0.00	61. 20
					1. 00	
ACA Provisions Affecting the Health Resources and Sec. 00 Enter the number of FTE residents that your hospital				ried for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru 62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) int			62. 01
Teaching Hospitals that Claim Residents in Nonproviders 63.00 Has your facility trained residents in nonproviders	ettings	during this c			N	63. 00
"Y" for yes or "N" for no in column 1. If yes, compl	ete iine	s o4 till ough	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in N	lonnrovi d	der Settings	1.00 This base vea	2.00	3.00	
period that begins on or after July 1, 2009 and before	re June	30, 2010.	0.			1
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter if of (column 1 divided by (column 1 + column 2)). (see	n-primar all non d non-pr n column instruc	0. 000000				
Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4. 00	5. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/31/2018 12:17 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	Financial Systems LUTHERAN MUSCULOSKELETAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi	CENTER der CCN: 15-0168	Period: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/31/2018 12:	epared:	
				1. 00		
	Long Term Care Hospital PPS	1.6		N.	00.00	
81. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N' Is this a LTCH co-located within another hospital for part or all o "Y" for yes and "N" for no. TEFRA Providers		ng period? Enter	N N	80. 00 81. 00	
85. 00 86. 00	s or "N" for no. on	N	85. 00 86. 00			
87. 00	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					
	1000(d)(1)(b)(v1): Effect 1 101 yes of N 101 ho.		V	XI X		
			1. 00	2. 00		
	Title V and XIX Services				1	
90. 00	Does this facility have title V and/or XIX inpatient hospital serviouses or "N" for no in the applicable column.	ces? Enter "Y" for	N	Υ	90.00	
	Is this hospital reimbursed for title V and/or XIX through the cost full or in part? Enter "Y" for yes or "N" for no in the applicable o		N	Υ	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual cert	fication)? (see		N	92. 00	
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. On Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					
95. 00 96. 00	if line 94 is "Y", enter the reduction percentage in the applicable Does title V or XIX reduce operating cost? Enter "Y" for yes or "N"		O. 00 N	0. 00 N	95. 00 96. 00	
97. 00 98. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable Does title V or XIX follow Medicare (title XVIII) for the interns a stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes o column 1 for title V, and in column 2 for title XIX.	nd residents post	O. 00 N	0. 00 Y	97. 00 98. 00	
98. 01	Cooks title V or XIX follow Medicare (title XVIII) for the reporting C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, a title XIX.			Υ	98. 01	
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation Doed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" fo For title V, and in column 2 for title XIX.		N	Y	98. 02	
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical accreimbursed 101% of inpatient services cost? Enter "Y" for yes or "N			N	98. 03	
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbur: outpatient services cost? Enter "Y" for yes or "N" for no in column		N d	N	98. 04	
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the M Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1			Υ	98. 05	
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimburs Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.		N	Υ	98. 06	
	Rural Providers		N1		105 00	
106.00	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusi	ve method of paymen	nt N		105. 00 106. 00	
107.00	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cost reimburtraining programs? Enter "Y" for yes or "N" for no in column 1. (see yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and	e instructions) If			107. 00	
108.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CRNA fe	e schedule? See 42	2 N		108. 00	
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	cal Occupation	al Speech	Respiratory		

85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section	"N" for no.	N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			
87.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87. 00
1000(d)(1)(b)(v1): Enter 1 101 yes of 14 101 no.	V	XI X	
	1. 00	2. 00	
Title V and XIX Services			
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Υ	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	97. 00
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98. 00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Υ	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	N	Υ	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Υ	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Υ	98. 06
Rural Providers			
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108. 00
Physi cal 0ccupati onal	Speech	Respi ratory	
1.00 2.00	3. 00	4. 00	100.05
109.00 f 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.			109. 00
		1. 00	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410	Α	1.00 N	110. 00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through applicable.	yes,	IV.	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	RELETAL CENTER Provider CCN: 15-0168	Peri od:		Worksheet S-	-2552-1 2
		From 01/01 To 12/31		Part I Date/Time Pr 5/31/2018 12	
		1. 00)	2. 00	+
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to confine in the properties of the FCHIP demo in which this CAH is participated and the properties of the FCHIP demo in which this CAH is participated and the project of the project of the participated and the project of the participated and the project of the participated and the	st reporting period? Ente lumn 1 is Y, enter the ticipating in column 2.	N N		2.00	111.0
Ni saal lagaaya Cast Dagaati ya lafayasti ya			1. 00	0 2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider: Pub. 15-1, chapter 22, \$2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	If column 2 is "E", enter t for long term care (inc s) based on the definition	er in column cludes	N N	0	115. 0
l17.00 s this facility legally-required to carry malpractice insurance.	ance? Enter "Y" for yes o		N		117. 0
118.00 Is the malpractice insurance a claims-made or occurrence pol- claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the polic	cy is	1		118. 0
	Premi ums	Losse	es	Insurance	
	1.00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	19,	153 4	13, 543	8	0 118. 0
		1.00)	2.00	
18.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 IDO NOT USE THIS LINE		N			118. 0
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes on alifies for the Outpatier	•		N	120. 0
21.00 Did this facility incur and report costs for high cost implainments? Enter "Y" for yes or "N" for no.	ntable devices charged to	Y			121. 0
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en		e			126. 0
in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, enting in column 1 and termination date, if applicable, in column 2	er the certification date				127. 0
28.00 If this is a Medicare certified liver transplant center, ent- in column 1 and termination date, if applicable, in column 2	er the certification date				128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col					130. 0
31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1	umn 2.				131. 0
32.00 If this is a Medicare certified islet transplant center, ent- in column 1 and termination date, if applicable, in column 2					132. 0
33.00 f this is a Medicare certified other transplant center, entin column 1 and termination date, if applicable, in column 2					133. 0
(134.00) If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2. All Providers	e uru number in column 1				134. 0
All Providers 40.00 Are there any related organization or home office costs as do	efined in CMS Pub. 15-1,	Υ		449008	140. 0

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: To 12/31/2017 5/31/2018 12:17 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH SYSTEMS | Contractor's Name: WISCONSIN PHYSICIA 141 00 Name: Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 52280 141 00 SERVI CES 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN State: Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν N N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. CBSA FTE/Campus State Zip Code Name County 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99 169. 00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2017 12/31/2017 170.00 period respectively (mm/dd/yyyy) 1.00 2.00 0171.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in Ν section 1876 Medicare cost plans reported 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, enter the number of section 1876 Medicare days in column 2. (see instructions)

	Financial Systems LUTHERAN MUSCULOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet S-2 Part II Date/Time Pre	2
	<u> </u>				5/31/2018 12:	
				Y/N 1. 00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions) Y/N	Date	V/I	
			1.00	2.00	3. 00	
00	Has the provider terminated participation in the Medicare P		N			2. 00
	yes, enter in column 2 the date of termination and in column	n 3, "V" for				
00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	a management	l N			3.00
	contracts, with individuals or entities (e.g., chain home o	ffices, drug				
	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 othe					
	relationships? (see instructions)					
			1. 00	7ype 2.00	3. 00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert		N			4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,				
	column 3. (see instructions) If no, see instructions.	irabie iii				
00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	onciliation.		Y/N	Legal Oper.	
				1, 00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	s N		6. 00
00	Are costs claimed for Allied Health Programs? If "Y" see in:	structions.		N		7. 00
00	Were nursing school and/or allied health programs approved	and/or renewed	l during the	N		8. 00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate medic	al education	N		9. 00
00	program in the current cost report? If yes, see instruction		ar caacatron	1		7.00
0. 00	Was an approved Intern and Resident GME program initiated o	r renewed in t	he current	N		10.00
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Pin an Ann	roved	N		11. 00
1. 00	Teaching Program on Worksheet A? If yes, see instructions.	a K III all App	n oved	14		11.00
					Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	, see instruct	i ons.		N	12.00
3. 00	If line 12 is yes, did the provider's bad debt collection p	olicy change c	luring this co	ost reporting	N	13.00
4 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	nts waived2 lf	Type soo ins	structions	N	14.00
4. 00	Bed Complement	its warveu: Ti	yes, see ms	structions.	IN .] 14.00
5. 00	Did total beds available change from the prior cost reporti				N	15. 00
		Y/N	t A Date	Par Y/N	t B Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Υ	04/03/2018	Y	04/03/2018	16.00
	date of the PS&R Report used in columns 2 and 4 . (see					
	instructions)					
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 0

19.00

but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN		Provi der CC	N: 15-0168	Peri od: From 01/01/2017	Worksheet S Part II		
					Date/Time P 5/31/2018 1:		
		Descri	pti on	Y/N	Y/N	2. 17 piii	
		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:			N	N	20.00	
	report data for other: bescribe 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 records? If yes, see instructions.	N		N		21. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)				
	Capital Related Cost						
2.00	Have assets been relifed for Medicare purposes? If yes, see		alo modo dur	ing the cost		22. 0 23. 0	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	ars made dur	ing the cost		23.0	
24. 00							
5. 00	Have there been new capitalized leases entered into during	the cost report	ting period?	'If yes, see		25. 0	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost renortir	na neriod? I	f ves see		26. 0	
3. 00	instructions.	is cost reportir	ig periou: I	, yes, see		20.0	
27. 00	Has the provider's capitalization policy changed during the	e cost reporting	g period? If	yes, submit		27. 0	
	copy. Interest Expense						
8. 00	Were new Loans, mortgage agreements or Letters of credit er	ntered into duri	ng the cost	reporting		28. 0	
	period? If yes, see instructions.						
9. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ot Service R	Reserve Fund)		29. 0	
80.00	Has existing debt been replaced prior to its scheduled matu	uctions urity with new o	debt? If yes	s, see		30.0	
	instructions.						
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new c	debt? If yes	s, see		31. 0	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		through co	ntractual		32. 0	
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33. 0	
	no, see instructions.						
4. 00	Provider-Based Physicians Are services furnished at the provider facility under an ar	crangement with	nrovi der_ha	sed nhysicians?		34.0	
74.00	If yes, see instructions.	rangement with	provider-be	ised physicians:		34.0	
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based		35. 0	
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	renared by the b	nome office?	,		36. 0 37. 0	
	If yes, see instructions.	epared by the r	ionie office:			37.0	
37. 00	If line 36 is yes , was the fiscal year end of the home off			-		38. 0	
37. 00 38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	d of the home of	fi ce.				
7. 00 8. 00	If line 36 is yes , was the fiscal year end of the home off	d of the home of	fi ce.				
37. 00 38. 00 39. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	d of the home of er chain compone	fice. ents? If yes			39. 0	
	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	d of the home of er chain compone	fice. ents? If yes			39. 0	
37. 00 38. 00 39. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	d of the home of er chain compone	ffice. ents? If yes f yes, see	S,	00	39. 0	
87. 00 88. 00 89. 00 -0. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	d of the home of er chain compone home office? I	ffice. ents? If yes f yes, see	2.	00	39. 0 40. 0	
37. 00 38. 00 39. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	d of the home of er chain compone home office? I	ffice. ents? If yes f yes, see	S,	00	38. 00 39. 00 40. 00	
37. 00 38. 00 39. 00 40. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home of er chain compone home office? I	ffice. ents? If yes f yes, see	2.	00	39. 00 40. 00 41. 00	
7. 00 8. 00 9. 00 0. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	d of the home of er chain compone home office? I	ffice. ents? If yes f yes, see	2.	00	39. 0 40. 0	
87. 00 88. 00 89. 00 -0. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	d of the home of er chain compone home office? I	ffice. ents? If yes f yes, see	2.		39. C 40. C	

Health Financial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIME	URSEMENT QUESTIONNAIRE	Provider CCN:	Peri od:	Worksheet S-	2	
			From 01/01/2017 To 12/31/2017	Date/Time Pr	epared:	
				5/31/2018 12	: 17 pm	
		3.00				
Cost Report Preparer Contact Info	ormation					
41.00 Enter the first name, last name	and the title/position	MGR			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 e	mail address of the cost				43.00	
report preparer in columns 1 and	respecti vel y.					
, , , ,		•	•		•	

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0168

					1	o 12/31/2017	Date/Time Pre 5/31/2018 12:		
							I/P Days / 0/P	17 piii	
							Visits / Trips		
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V		
		Line Number			Avai I abl e				
		1.00		2. 00	3.00	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		39	14, 235	0.00	0	1. 00	ō
	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	0
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00	0
7.00	Total Adults and Peds. (exclude observation			39	14, 235	0.00	0	7.00	0
	beds) (see instructions)								
8. 00	INTENSIVE CARE UNIT	31. 00		0			1	8.00	
9. 00	CORONARY CARE UNIT	32. 00	1	0	1		l .	9.00	
10. 00	BURN INTENSIVE CARE UNIT	33. 00		0	1		l	10.00	
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	(0.00	0	11. 00	
12. 00	OTHER SPECIAL CARE (SPECIFY)						_	12.00	
13. 00	NURSERY	43. 00					0	13.00	
14. 00	Total (see instructions)			39	14, 235	0. 00		14.00	
15. 00	CAH visits			_	_		0	15.00	
16. 00	SUBPROVI DER - I PF	40. 00		0			0	16.00	
17. 00	SUBPROVI DER - I RF	41. 00		0	C)	0	17.00	
18.00	SUBPROVI DER	44.00						18.00	
19.00	SKILLED NURSING FACILITY	44. 00		0			0	19.00	
20.00	NURSING FACILITY	45. 00		0			0	20.00	
21. 00	OTHER LONG TERM CARE	46.00		Ü	1	,	0	21.00	
22. 00	HOME HEALTH AGENCY	101.00					0	22. 00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115.00		0	,			23. 00 24. 00	
24. 00 24. 10	HOSPICE	116.00		U	'	,		24.00	
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00 99. 00					0	25. 0	
25. 00	CMHC - CORF	99. 10					0	25. 00	
26. 00	RURAL HEALTH CLINIC	88. 00						26. 0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 0	
27. 00	Total (sum of lines 14-26)	09.00		39			0	27. 0	
28. 00	Observation Bed Days			37			0	28.00	
29. 00	Ambulance Trips						0	29.00	
30. 00	Employee discount days (see instruction)							30.00	
31. 00	Employee discount days (see Fristraction)							31.00	
32. 00	Labor & delivery days (see instructions)			0				32.00	
32. 00	Total ancillary labor & delivery room			O				32. 0°	
32.01	outpatient days (see instructions)							32.0	
33. 00	LTCH non-covered days							33.00	0
	LTCH site neutral days and discharges							33. 0	
		•			•	•	•		

Provider CCN: 15-0168

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/31/2018 | 12:17 pm

						5/31/2018 12:	17 pm
		I/P Days	o/ O/P Visits	/ Trips	Full Time	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 863	326	5, 634			1. 00
	for the portion of LDP room available beds)		_				
2. 00	HMO and other (see instructions)	1, 295	0				2. 00
3. 00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0	_			4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 863	326	5, 634			7. 00
0.00	beds) (see instructions)		0				0.00
8.00	INTENSIVE CARE UNIT	0	0	O			8. 00
9.00	CORONARY CARE UNIT	0	0	U			9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	U			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	C			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	4 0/0	0	5 (04	0.00	000.07	13.00
14.00	Total (see instructions)	1, 863	326	5, 634	0.00	230. 86	
15.00	CAH visits	0	0	U	0.00	0.00	15.00
16.00	SUBPROVI DER - I PF	0	0	O			
17.00	SUBPROVIDER - I RF	0	0	C	0.00	0.00	
18.00	SUBPROVI DER		0		0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	O			
20.00	NURSING FACILITY		U	O		l e	
21. 00	OTHER LONG TERM CARE		0	O	0.00		
22. 00	HOME HEALTH AGENCY	0	0	C		l e	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		0		0.00		
24. 00	HOSPI CE	0	0	0	0.00	0.00	
24. 10	HOSPICE (non-distinct part)	0	0		0.00	0.00	24. 10
25. 00 25. 10	CMHC - CMHC		0	0		l	
	CMHC - CORF		-	0	0.00		
26. 00	RURAL HEALTH CLINIC		0	_			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	U	U	C		l	
27. 00	Total (sum of lines 14-26)		0	307	0.00	230. 86	
28. 00	Observation Bed Days	o	0	307			28. 00
29. 00	Ambulance Trips	٩					29. 00 30. 00
30.00	Employee discount days (see instruction)			0			
31.00	Employee discount days - IRF		0	U			31.00
32.00	Labor & delivery days (see instructions)	0	O	0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33.00	LTCH non-covered days	О					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

 Heal th Financial
 Systems
 LUTHERAN M

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-0168

In Lieu of Form CMS-2552-10 Peri od: Worksheet S-3 Part I Date/Time Prepared: 5/31/2018 12:17 pm.

						5/31/2018 12:	17 pm
		Full Time Equivalents	·		narges		·
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		(773	128	2, 445	1.00
2.00	HMO and other (see instructions)			508	ol		2.00
3.00	HMO IPF Subprovider				o		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	(773	128	2, 445	1
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF	0.00	(ol	0	16. 00
17.00	SUBPROVI DER - I RF	0.00	(o	0	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY	0.00					20. 00
21.00	OTHER LONG TERM CARE	0.00				0	21. 00
22.00	HOME HEALTH AGENCY	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24.00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26.00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	1			(33. 00
33. 01	LTCH site neutral days and discharges				'l l		33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0168

					To	12/31/2017	Date/Time Prep 5/31/2018 12:	
		Wkst. A Line	Amount	Recl assi fi cati	,		Average Hourly	т ріп
		Number	Reported	on of Salaries (from Wkst.	Sal ari es (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col . 4	COI : 3)	
	PART II - WAGE DATA	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES							
1.00	Total salaries (see instructions)	200. 00	14, 042, 000	0	14, 042, 000	480, 188. 00	29. 24	1. 00
2.00	Non-physician anesthetist Part		0	О	0	0.00	0.00	2. 00
3. 00	A Non physician aposthotist Part		0	0	0	0.00	0. 00	3. 00
3.00	Non-physician anesthetist Part B		U			0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	О	0	0.00	0. 00	4. 01
5.00	Physician and Non		0	0	0	0. 00	0. 00	5. 00
6. 00	Physician-Part B Non-physician-Part B for		0	О	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC							
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
	approved program)		_	_				
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
	programs)							
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	0	О	0	0.00		9. 00
10. 00	Excluded area salaries (see instructions)		1, 358, 902	110, 163	1, 469, 065	3, 645. 00	403. 04	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		221, 092	0	221, 092	4, 778. 00	46. 27	11. 00
12. 00	Contract Labor: Top Level		0	О	0	0.00	0. 00	12. 00
	management and other management and administrative							
	servi ces							
13. 00	Contract Labor: Physician-Part A - Administrative		33, 946	0	33, 946	234. 00	145. 07	13. 00
14. 00	Home office and/or related		0	0	0	0.00	0. 00	14. 00
	orgainzation salaries and							
14. 01	wage-related costs Home office salaries		1, 792, 981	0	1, 792, 981	52, 001. 00	34. 48	14. 01
14. 02	Related organization salaries		0	0	0	0.00		14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract		0	О	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		3, 334, 930	0	3, 334, 930			17. 00
18. 00	instructions) Wage-related costs (other)		144, 335	0	144, 335			18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		264	0				19. 00 20. 00
20.00	A		O	Ĭ				20.00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	О	o			22. 00
22. 01	Administrative Physician Part A - Teaching		0	_				22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		0	o	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
	wage-related (core)							
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							
25. 53	Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	ES 4. 00	0	Γο	O	0.00	0.00	26. 00
27. 00	Administrative & General	5. 00	2, 512, 751			124, 169. 75		27. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0168

							5/31/2018 12:	17 pm_
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		C	0	C	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	C	0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	43, 446	0	43, 446			30. 00
31. 00	Laundry & Linen Service	8. 00	C	0	0	0.00	0. 00	31. 00
32.00	Housekeepi ng	9. 00	C	0	C	0.00	0.00	32. 00
33.00	Housekeeping under contract		348, 288	0	348, 288	28, 678. 57	12. 14	33.00
	(see instructions)							
34.00	Di etary	10. 00	C	0	C	0.00	0.00	34.00
35.00	Di etary under contract (see		24, 725	0	24, 725	1, 355. 00	18. 25	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	C	0	C	0.00	0. 00	36. 00
37.00	Maintenance of Personnel	12. 00	C	0	C	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	223, 601	111, 816	335, 417	8, 825. 00	38. 01	38. 00
39. 00	Central Services and Supply	14. 00	449, 177	0	449, 177	25, 257. 00	17. 78	39. 00
40.00	Pharmacy	15. 00	189	0	189	8. 00	23. 63	40.00
41.00	Medical Records & Medical	16. 00	9, 016	0	9, 016	464.00	19. 43	41.00
	Records Library							
42.00	Social Service	17. 00	C	0	C	0.00	0. 00	42.00
43.00	Other General Service	18. 00	C	0	C	0.00	0. 00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION LUTHERAN MUSCULOSKELETAL CENTER

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part III | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0168

					''	0 12/31/201/	5/31/2018 12: 1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		14, 415, 013	0	14, 415, 013	510, 221. 57	28. 25	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 358, 902	110, 163	1, 469, 065	3, 645. 00	403. 04	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		13, 056, 111	-110, 163	12, 945, 948	506, 576. 57	25. 56	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		2, 048, 019	0	2, 048, 019	57, 013. 00	35. 92	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		3, 479, 265	0	3, 479, 265	0.00	26. 88	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		18, 583, 395	-110, 163	18, 473, 232	563, 589. 57	32. 78	6. 00
7.00	Total overhead cost (see		3, 611, 193	-110, 163	3, 501, 030	190, 340. 32	18. 39	7. 00
	instructions)							

	10 12/31/2017	5/31/2018 12: 1	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		l
	RETI REMENT COST		l
1.00	401K Employer Contributions	259, 568	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	1, 849, 631	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	9, 068	10.00
11. 00	1	10, 439	11. 00
12.00			12. 00
13.00		2, 910	13. 00
14.00		0	14. 00
15. 00		214, 382	
16. 00		0	16. 00
	Non cumulative portion)		ı
	TAXES		
	FICA-Employers Portion Only	765, 474	
	Medicare Taxes - Employers Portion Only	179, 022	
19. 00		0	19. 00
20. 00	State or Federal Unemployment Taxes	44, 728	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	l
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0	
24. 00	and a grant and the contract of	3, 335, 194	24. 00
	Part B - Other than Core Related Cost	444	
25.00	BENEFITS - OTHER	144, 335	25.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	LETAL CENTER In Lieu			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0168		Worksheet S-3		
		From 01/01/2017			

		To 12/31/2017					
	Cost Center Description	Contract Labor	5/31/2018 12: Benefit Cost	17 piii			
	COST CONTROL DESCRIPTION	1. 00	2. 00				
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identification:						
1.00	Total facility's contract labor and benefit cost	221, 092	3, 335, 194	1. 00			
2.00	Hospi tal	221, 092	3, 335, 194	2. 00			
3.00	Subprovi der - I PF	0	0	3. 00			
4.00	Subprovi der - I RF	0	0	4. 00			
5.00	Subprovi der - (Other)	0	0	5. 00			
6.00	Swing Beds - SNF	0	0	6. 00			
7.00	Swing Beds - NF	0	0	7. 00			
8.00	Hospi tal -Based SNF	0	0	8. 00			
9.00	Hospi tal -Based NF	0	0	9. 00			
10.00	Hospi tal -Based OLTC			10.00			
11. 00	Hospi tal -Based HHA	0	0	11. 00			
12.00	Separately Certified ASC	0	0	12.00			
	Hospi tal -Based Hospi ce	0	0	13. 00			
14. 00	Hospital-Based Health Clinic RHC	0	0	14.00			
15. 00	Hospital-Based Health Clinic FQHC	0	0	15. 00			
16. 00	Hospi tal -Based-CMHC	0	0	16. 00			
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10			
	Renal Di al ysi s	0	0	17. 00			
18. 00	Other	0	0	18. 00			

SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-0168	Peri od:	_ Worksheet S-	10
			From 01/01/201		00000
			To 12/31/201	7 Date/Time Pro 5/31/2018 12	
				1. 00	
	Uncompensated and indigent care cost computation			_	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 colu	ımn 8)	0. 108113	3 1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid			3, 407, 16	7 2.
00	Did you receive DSH or supplemental payments from Medicaid?			3, 407, 10. Y	1 3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?	Ϋ́	4
00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d			0 5
00	Medicaid charges	27, 739, 86			
00	Medicaid cost (line 1 times line 6)			2, 999, 040	
00	Difference between net revenue and costs for Medicaid program (line < zero then enter zero)	ne / minus sum of I	ines 2 and 5; if	(0 8.
	Children's Health Insurance Program (CHIP) (see instructions for a	each line)			
00	Net revenue from stand-alone CHIP				0 9
00	Stand-alone CHIP charges				0 10
00	Stand-alone CHIP cost (line 1 times line 10)				0 11
00	Difference between net revenue and costs for stand-alone CHIP (li	ne 11 minus line 9;	if < zero then		0 12
	enter zero) Other state or local government indigent care program (see instruc	ctions for each lir	ne)		
00	Net revenue from state or local indigent care program (Not include			24, 29	9 13
00	Charges for patients covered under state or local indigent care p			518, 025	
	10)				
00	State or local indigent care program cost (line 1 times line 14)			56, 009	
00	Difference between net revenue and costs for state or local indig				
	12: if a zoro than onter zoro)	ent care program (i	THE IS IIITIUS ITT	31,700	0 16
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP a				6 16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line)	and state/local inc		ams (see	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund	and state/local inc		ams (see	0 17
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	and state/local inc	ligent care progr	ams (see	0 17 0 18
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in	and state/local inc	ligent care progr	ams (see	0 17 0 18
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	and state/local inc	digent care progr	ams (see	0 17 0 18 6 19
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients	digent care programs (sum of lines described linsured patients	ams (see (31,700) Total (col. 1 + col. 2)	0 17 0 18 6 19
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	and state/local inc ing charity care pital operations ndigent care progra	ligent care progr mms (sum of lines	ams (see () () () () () () () () () () () () ()	0 17 0 18 6 19
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line)	and state/local inding charity care pital operations ndigent care progrations Uninsure patients 1.00	mms (sum of lines d Insured s patients 2.00	ams (see (31,700 Total (col. 1 + col. 2) 3.00	0 17 0 18 6 19
00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients 1.00	mms (sum of lines d Insured s patients 2.00	ams (see (31,700) Total (col. 1 + col. 2) 3.00	0 17 0 18 6 19
00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities instructions) Cost of patients approved for charity care and uninsured discounts.	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients 1.00 ity 1,971,	d Insured patients 2.00	ams (see (31,700 Total (col. 1 + col. 2) 3.00	0 17 0 18 6 19 0 20
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients 1.00 ity 1,971, s (see 213,	d Insured patients 2.00	ams (see () () () () () () () () () () () () ()	0 177 0 188 6 19 0 20 7 21
00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients 1.00 ity 1,971, s (see 213,	d Insured patients 2.00	ams (see () () () () () () () () () () () () ()	0 17 0 18 6 19 0 20 7 21
00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	and state/local inc ing charity care pital operations ndigent care progra Uninsure patients 1.00 ity 1,971, s (see 213,	digent care programs (sum of lines described patients 2.00	ams (see () () () () () () () () () () () () ()	0 17 0 18 6 19 0 20 7 21 0 22
00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care	and state/local incomplete ing charity care pital operations and gent care progrations are patients and gent care progrations and gent care progrations are progrations are progrations and gent care progrations are progrations are progrations are progrations are progrations and gent care progrations are programmed as a programmed are pro	digent care programs (sum of lines described patients 2.00	ams (see (31,700 Total (col. 1 + col. 2) 3.00 0 1,971,060 0 213,09	0 17 0 18 6 19 0 20 7 21 0 22
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilities instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	and state/local incoming charity care pital operations ndigent care progrations and gent care progrations and gent care progrations and gent care progrations are patients and the state of	d Insured patients 2.00 060 097	ams (see (31,700 Total (col. 1 + col. 2) 3.00 0 1,971,060 0 213,090 0 213,090	0 17 0 18 6 19 0 20 7 21 0 22 7 23
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patients	and state/local incoming charity care pital operations ndigent care progrations and gent care progrations. Uninsure patients 1.00 ity 1,971, s (see 213, gray 213, g	d Insured patients 2.00 060 097	ams (see (31,700 Total (col. 1 + col. 2) 3.00 0 1,971,060 0 213,09	0 17 0 18 6 19 0 20 7 21 0 22
00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the	and state/local incompanies in the ingression of	digent care programs (sum of lines described patients 2.00	ams (see 31,700 Total (col. 1 + col. 2) 3.00 0 213,09 0 213,09 1.00 N	00 177 00 188 01 199 01
00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care process.	and state/local incoming charity care pital operations ndigent care progrations and gent care progrations. Uninsure patients 1.00 ity 1,971, s (see 213, f as 213, days beyond a length ogram? indigent care program?	digent care programs (sum of lines described patients 2.00	ams (see 31,700 Total (col. 1 + col. 2) 3.00 0 213,09 0 213,09 1.00 N	00 177 01 188 01 199 01
00 00 00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the stay limit	and state/local incoming charity care pital operations ndigent care progrations and gent care progration ity and pital local l	digent care programs (sum of lines described patients 2.00	ams (see (31,700 Total (col. 1 + col. 2) 3.00 0 1,971,060 0 213,090 0 213,090	200 177 21 200 22 24 24 24 25 25 26 26 27 23
00 00 00 00 00 00 00 00 00 00 01	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profit in 24 is yes, enter the charges for patient days beyond the stay limit total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	and state/local incomplete ing charity care pital operations and gent care progrations and gent care progration ity and the state of th	digent care programs (sum of lines described patients 2.00	ams (see 31, 706 Total (col. 1 + col. 2) 3.00 0 1, 971, 060 0 213, 090 0 213, 090 1.00 N 1, 923, 920 74, 63 114, 820	00 177 21 23 24 24 25 00 25 00 26 33 277 00 27 27 00 2
00 00 00 00 00 00 00 00 00 01 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profile in 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instrumedicare eimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	and state/local indigent care program? ing charity care pital operations and gent care program? ity 1,971, s (see 213, days beyond a length ogram? indigent care program. indigent care program. indigent care program. indigent care program. instructions)	digent care programs (sum of lines described patients 2.00 060 097 0 097 ch of stay limit ram's length of	ams (see 31,700 Total (col. 1 + col. 2) 3.00 0 213,09 0 213,09 1.00 N (1,923,920 74,633 114,820 1,809,100	00 177 21 24 24 24 25 25 26 27 28 3 27 27 28 27 27 28 27 27 27 27 27 27 27 27 27 27 27 27 27
00 00 00 00 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profit in 24 is yes, enter the charges for patient days beyond the stay limit total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	and state/local indigent care program? ing charity care pital operations and gent care program? ity 1,971, s (see 213, days beyond a length ogram? indigent care program. indigent care program. indigent care program. indigent care program. instructions)	digent care programs (sum of lines described patients 2.00 060 097 0 097 ch of stay limit ram's length of	ams (see 31, 706 Total (col. 1 + col. 2) 3.00 0 1, 971, 060 0 213, 090 0 213, 090 1.00 N 1, 923, 920 74, 63 114, 820	00 177 21 22 24 24 29 26 27 0 28 44 29

	Financial Systems L SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UTHERAN MUSCULOSK	Provider Co		In Lie Period:	u of Form CMS-: Worksheet A	2552-10
KLOLAS	STITE OF THE BALANCE	OI EXIENSES	Trovider Co		From 01/01/2017 Fo 12/31/2017	Date/Time Pre	nared:
						5/31/2018 12:	
	Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
						(col. 3 +-	
		1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
1 00	GENERAL SERVICE COST CENTERS		70.004	70.00	4 700 000	4 070 000	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		79, 934 1, 152, 571	1		4, 872, 323 1, 375, 400	1. 00 2. 00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 2, 512, 751	105, 720 33, 774, 352			2, 368, 444 29, 685, 679	1
7. 00	00700 OPERATION OF PLANT	43, 446	1, 115, 307			1, 850, 459	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	96, 848	1		96, 848	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		417, 074 273, 049			415, 634 272, 948	
12. 00	01200 MAINTENANCE OF PERSONNEL	O	0		0	0	12. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	223, 601 449, 177	427, 808 15, 349, 752	1	· ·	840, 986 1, 143, 951	1
15. 00	01500 PHARMACY	189	1, 888, 287			513, 352	
16.00	01600 MEDI CAL RECORDS & LI BRARY	9, 016	766, 979	775, 99!	-5, 121	770, 874	1
17. 00 18. 00	01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CES		0			0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0		0	0	19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	20.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	o o	0			0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	(0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 004, 869	517, 079	2, 521, 948	-1, 458	2, 520, 490	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	_,,	0	0	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	34. 00
40.00	04000 SUBPROVIDER - I PF	o	0		0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0			0	
44. 00	04400 SKILLED NURSING FACILITY	Ö	0		o o	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	0	
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	1	5 0	0	40.00
50.00	05000 OPERATI NG ROOM	3, 812, 578	6, 064, 718			9, 777, 162	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	1, 328, 637	424, 157 0	1, 752, 794		0	
53.00	05300 ANESTHESI OLOGY	0	33, 171			0	53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	149, 531	345, 814 3, 963		· ·	398, 055 3, 963	1
	05500 RADI OLOGY-THERAPEUTI C	o o	3, 703	3, 70.		0	1
	05600 RADI OI SOTOPE	0	0	(0	0	
57.00	05700 CT SCAN 05800 MRI	500	3, 727 4, 201			3, 727 4, 701	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 691	414, 999	418, 690	-321	418, 369 0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O	0		0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0	63. 00 64. 00
65.00	06500 RESPIRATORY THERAPY	ō	14, 455	1		14, 455	65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 833, 168 311, 730	751, 220			2, 413, 423 0	1
68. 00	l l	214	22, 072 30	1	· ·	0	1
	06900 ELECTROCARDI OLOGY	0	20, 161	20, 16	0		69.00
70. 00 71. 00	1 · · · · · · · · · · · · · · · · · · ·		0		0 636, 036	0 636, 036	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0		14, 165, 248	14, 165, 248	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		1, 255, 154	1, 255, 154 0	1
	07500 ASC (NON-DISTINCT PART)		0		0 0	0	1
	OUTPATIENT SERVICE COST CENTERS					_	
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
90. 00	09000 CLI NI C	Ö	0			0	90.00
91.00	09100 EMERGENCY	0	0		0	0	91. 00 92. 00
92. UU	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			<u> </u>			J 92. UU
	09400 HOME PROGRAM DIALYSIS	0	0		0	0	
95. 00	09500 AMBULANCE SERVI CES	0	0	<u>'</u>	0	0	95. 00

Health Financial Systems	LUTHERAN MUSCULOSKE	ELETAL CEN	TER		In Lieu of Form CMS-2552-10	1
				T		

Health Financial Systems LU	THERAN MUSCULOSK	ELETAL CENTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN		eri od:	Worksheet A	
				rom 01/01/2017		
				o 12/31/2017	Date/Time Pre 5/31/2018 12:	
Cost Center Description	Sal ari es	Other 1		Recl assi fi cati		17 pili
cost center bescription	Jai ai i es	Other	+ col . 2)		Tri al Balance	
			1 001. 2)	0113 (300 71 0)	(col . 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	C	o	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	o	0	C	o	0	98. 00
99. 00 09900 CMHC	o	0	C	o	0	99. 00
99. 10 09910 CORF	o	O	C	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	C	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	C	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	C	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	C	0	0	111. 00
113.00 11300 I NTEREST EXPENSE		0	C	0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	C	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0		115. 00
116. 00 11600 HOSPI CE	0	0	C	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 683, 098	64, 067, 448	76, 750, 546	-912, 704	75, 837, 842	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	이		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	817	15, 514	16, 331	-1, 495	· ·	192. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0		193. 00
194. 00 07950 MARKETI NG	1, 358, 085	531, 466	1, 889, 551	914, 199	2, 803, 750	
194. 01 07951 SENI OR CI RCLE	0	0	C	0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 042, 000	64, 614, 428	78, 656, 428	0	78, 656, 428	200. 00

Provider CCN: 15-0168

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/31/2018 12: 17 pm

			5/31/2018 12:	17 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	<u> </u>			
1.00 00100 CAP REL COSTS-BLDG & FLXT	-3, 300, 632			1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	19, 826	1		2.00
3. 00 00300 OTHER CAP REL COSTS	2.053	1		3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL	-2, 953 -20, 255, 748			4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	-20, 255, 746			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	-15, 207	81, 641		8.00
9. 00 00900 HOUSEKEEPI NG	13, 23,	1		9. 00
10. 00 01000 DI ETARY				10.00
12.00 01200 MAINTENANCE OF PERSONNEL				12. 00
13.00 01300 NURSING ADMINISTRATION	-50	840, 936		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY		1, 143, 951		14. 00
15. 00 01500 PHARMACY	C			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	770, 874		16. 00
17. 00 01700 SOCIAL SERVICE		0		17. 00
18. 00 01850 OTHER GENERAL SERVICES		0		18.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS				19. 00 20. 00
20. 00 02000 NURSI NG SCHOOL	-			21.00
22. 00 02200 I&R SERVICES-OTHER PRGM COSTS				22. 00
23. 00 02300 PARAMED ED PRGM	AT IX	1 1		23. 00
INPATIENT ROUTINE SERVICE COST CENT		<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS	C	2, 520, 490		30.00
31.00 03100 INTENSIVE CARE UNIT		0		31. 00
32.00 03200 CORONARY CARE UNIT		0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	C	0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	C	1		34. 00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		41.00
43. 00 04300 NURSERY		0		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY		1		44.00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE				45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>		40.00
50. 00 05000 OPERATING ROOM		9, 777, 162		50.00
51. 00 05100 RECOVERY ROOM				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1		52.00
53. 00 05300 ANESTHESI OLOGY		0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		398, 055		54.00
54.01 03630 ULTRA SOUND	C	3, 963		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00 05600 RADI 0I SOTOPE		0		56. 00
57. 00 05700 CT SCAN		-,		57. 00
58. 00 05800 MRI				58. 00 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		1		60.00
60. 01 06001 BLOOD LABORATORY				60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRO		0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOO		o		62.00
63. 00 06300 BLOOD STORING, PROCESSING & T	•	o		63. 00
64. 00 06400 I NTRAVENOUS THERAPY		O		64. 00
65. 00 06500 RESPIRATORY THERAPY		14, 455		65. 00
66. 00 06600 PHYSI CAL THERAPY		2, 413, 423		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0		67. 00
68.00 06800 SPEECH PATHOLOGY	C	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	20, 161		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY) C	0		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO F	l l	636, 036		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		1 , ,		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS		., = ,		73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)		1		74. 00 75. 00
OUTPATIENT SERVICE COST CENTERS		U U		/ 5. 00
88. 00 08800 RURAL HEALTH CLINIC		0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CE		n		89. 00
90. 00 09000 CLINIC		n		90.00
91. 00 09100 EMERGENCY		l ol		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTING	T PART			92.00
OTHER REIMBURSABLE COST CENTERS				[
94.00 09400 HOME PROGRAM DIALYSIS	C	0		94. 00
95. 00 09500 AMBULANCE SERVICES	C	1		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C	1 1		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00

 Health Financial
 Systems
 LUTHERAN MUSC

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-2552-10

Provider CCN: 15-0168

			10	12/31/201/	5/31/2018 12:17 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For 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
101.00 10100 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 UTILIZATION REVIEW-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 through 117)	-23, 562, 934	52, 274, 908			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 PHYSI CLANS' PRI VATE OFFI CES	0	14, 836			192. 00
193.00 19300 NONPALD WORKERS	0	0			193. 00
194. 00 07950 MARKETI NG	0	2, 803, 750			194. 00
194. 01 07951 SENI OR CI RCLE	0	0			194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-23, 562, 934	55, 093, 494			200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0168

					10		Date/IIMe Prepared: 5/31/2018 12:17 pm
		Increases			<u> </u>	- '	
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
1 00	A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4 00	ما	2 2/2 724			1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	2, 262, 724 0			1. 00 2. 00
3.00		0.00	0	0			3.00
0.00	TOTALS — — — —			2, 262, 724			0.00
	B - OXYGEN COSTS	· ·	- 1	, , , ,			
1.00		0.00	0	0			1. 00
	TOTALS		0	0			
1 00	C - RENTAL AND LEASE	1 00	ol	4 227 01/			1.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	4, 227, 816 216, 215			1. 00 2. 00
3.00	CAF REE COSTS-WVBEE EQUIF	0.00	0	210, 213			3.00
4. 00		0.00	ő	Ö			4. 00
5.00		0.00	o	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0.00		0			7. 00
	TOTALS		0	4, 444, 031			
1. 00	D - OTHER CAPITAL COST CAP REL COSTS-BLDG & FIXT	1.00	0	70, 256			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	o	494, 317			2.00
3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	6, 614			3.00
	TOTALS			571, 187			
	E - DEFAULT						
1.00	OPERATION OF PLANT	7. 00	0	691, 706			1. 00
2.00		0.00	0	0			2.00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5.00		0.00	0	o			5. 00
6. 00		0.00	o	Ö			6. 00
7.00		0.00	o	0			7. 00
8.00		0.00	0	0			8. 00
9.00		0.00	0	0			9.00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12. 00		0.00	0	0			12. 00
13. 00		0.00	ő	Ö			13. 00
14.00		0.00	o	0			14. 00
	TOTALS		0	691, 706			
	F - MARKETING	404.00	440.440	224 272			
1. 00	MARKETI NG	19400	11 <u>0, 1</u> 63 110, 163	83 <u>4, 3</u> 70 834, 370			1.00
	G - CHIEF NURSING OFFICER		110, 103	034, 370			
1.00	NURSI NG ADMI NI STRATI ON	13. 00	111, 816	77, 828			1.00
	TOTALS — — — —		111, 816	77, 828			
	H - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	636, 036			1.00
2 00	PATIENT IMPL. DEV. CHARGED TO	72. 00	o	14 145 240			2. 00
2.00	PATIENTS	72.00	U	14, 165, 248			2.00
	TOTALS			14, 801, 284			
	I - DRUGS/IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	7300	0	<u>1, 255, 1</u> 54			1.00
	TOTALS		0	1, 255, 154			
1 00	J - MISC DEPTS	44 00	211 044	22 102			1 00
1. 00 2. 00	PHYSI CAL THERAPY	66. 00 0. 00	311, 944	22, 102 0			1. 00 2. 00
2.00	TOTALS — — — —		311, 944	22, 102			2.00
	K - OTHER		2717711	22, .32			
1.00	OPERATING ROOM	50.00	1, 328, 637	456, 680			1. 00
2.00		0.00	0	0			2. 00
F00 0-	TOTALS		1, 328, 637	456, 680			500 55
500.00	Grand Total: Increases		1, 862, 560	25, 417, 066			500. 00

| Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0168

COST CENTER						10		3 12:17 pm
Column C			Decreases		<u>'</u>		, , , , , , , , , , , , , , , , , , , ,	
A - EMPLOYEE BENEFITS		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
1.00 ADMINISTRATIVE & GENERAL 5.00 0 2,262,703 0 0 0 0 0 0 0 0 0		6. 00	7. 00	8. 00	9. 00	10. 00		
2.00 MURSING AMM INSTRATION 13.00 0 17 0 10 10 10 10 10								
MEDICAL RECORDS & LIBRARY 16.00 0 2,262,724		ı ı	•	0		1		1.00
TOTALS	2.00		13. 00	0	17	0		2. 00
B - OXYGEN COSTS	3.00		<u>16.</u> 00	0	4			3. 00
1.00				0	2, 262, 724			
TOTALS C - RENTAL AND LEASE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 1 4.1299 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9		B - OXYGEN COSTS						
C - RENTAL AND LEASE 1.00 ADMIN STRATIVE & GENERAL 5.00 0 2.424, 412 9 2.00 CENTRAL SERVICES & SUPPLY 14.00 0 41, 299 9 3.00 PHARMACY 15.00 0 89, 245 0 4.00 MEDICAL RECORDS & LIBRARY 16.00 0 75, 117 0 5.00 OPERATING ROOM 50.00 0 1, 361, 826 0 6.00 RADIOLOGY-DIAGNOSTIC 54.00 0 78, 031 0 7.00 PHASTICAL THERAPY 66.00 0 44, 441, 001 0 7.01 TOTALS 0 0 44, 444, 031 0 7.01 DIAGNOSTIC 54.00 0 571, 187 12 7.02 DIAGNOSTIC 54.00 0 571, 187 12 7.03 ADMINISTRATIVE & GENERAL 5.00 0 571, 187 12 7.04 ADMINISTRATIVE & GENERAL 5.00 0 571, 187 12 7.05 ADMINISTRATIVE & GENERAL 5.00 0 133 0 12 7.07 ADMINISTRATIVE & GENERAL 5.00 0 0 571, 187 12 7.08 ADMINISTRATIVE & GENERAL 5.00 0 0 133 0 12 7.09 ADMINISTRATIVE & GENERAL 5.00 0 0 0 12 7.00 ADMINISTRATIVE & GENERAL 5.00 0 0 0 12 7.00 ADMINISTRATIVE & GENERAL 5.00 0 0 0 12 7.00 ADMINISTRATIVE & GENERAL 5.00 0 0 0 1440 0 0 0 0 0 12 7.00 ADMINISTRATIVE & GENERAL 5.00 0 0 0 1, 440 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		0.00					1. 00
1.00 ADMINISTRATIVE & GENERAL 5.00 0 2,424,412 9 9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				0	0			
2.00 CENTRAL SERVICES & SUPPLY 14.00 0 41.299 9								
PHARDMACY		I I	•	0		1		1. 00
MEDICAL RECORDS & LIBRARY 16.00 0 5.117 0 0 0 0 0 0 0 0 0		I I	•	0	•			2. 00
Deep Content of the		I I	I	0		1		3. 00
RADI OLOGY-DI AGNOSTIC 54. 00 0 78. 031 0 7. 00		I I	•	0		1		4. 00
PHYSICAL THERAPY				0		1		5. 00
TOTALS		1		0		1		6. 00
D - OTHER CAPITAL COST ADMINISTRATIVE & GENERAL D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00		6600					7. 00
ADMINISTRATIVE & GENERAL 5.00 0 571, 187 12 12 12 12 12 12 12 1				0	4, 444, 031			
2.00								
1.00		ADMINISTRATIVE & GENERAL		- 1				1. 00
TOTALS				0	0			2. 00
Color	3.00		0.00		0			3. 00
1.00				0	571, 187			
2.00								
3.00		1						1. 00
4. 00 NURSING ADMINISTRATION 13. 00 0 50 0 5. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 33, 219 0 6. 00 PHARMACY 15. 00 0 30, 725 0 7. 00 ADULTS & PEDIATRICS 30. 00 0 1, 458 0 8. 00 OPERATING ROOM 50. 00 0 302, 801 0 9. 00 RECOVERY ROOM 51. 00 0 302, 801 0 10. 00 RADIOLOGY-DI AGNOSTIC 54. 00 0 19, 259 0 11. 00 LABORATORY 60. 00 0 321 0 12. 00 PHYSI CAL THERAPY 66. 00 0 321 0 14. 00 MARKETING 194. 00 0 40, 910 0 14. 00 MARKETING 194. 00 0 30, 334 0 10 TOTALS 0 0 691, 706 F - MARKETING 1. 00 ADMINISTRATIVE & GENERAL 5. 00 110, 163 834, 370 0 10 TOTALS 110, 163 834, 370 0 10 TOTALS 111, 816 77, 828 0 10 CENTRAL SERVICES & SUPPLY 14. 00 0 14, 580, 460 0 10 CENTRAL SERVICES & SUPPLY 14. 00 0 14, 801, 284 1 1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 14, 801, 284 1 1. 00 PHARMACY 15. 00 12, 255, 154 1 1. 00 PHARMACY 15. 00 12, 255, 154 1 1. 00 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 1 TOTALS 0 1, 255, 154 1 2. 00 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 1, 255, 154 30 0 10 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 1, 255, 154 30 0 10 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 1, 255, 154 30 0 10 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 1, 255, 154 30 0 10 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 1, 255, 154 30 0 10 OCCUPATIONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 OPERATING ROOM 50. 00 214 30 0 2. 00 OPERATING ROOM 50. 00 311, 730 22, 072 0 311, 944 22, 102		1		-	•			2. 00
5.00 CENTRAL SERVICES & SUPPLY		1	I .	0		1		3. 00
6. 00 PHARMACY 15. 00 0 30, 725 0 0 7. 00 ADULTS & PEDIATRICS 30. 00 0 1, 458 0 0 9 8. 00 9 PERATING ROOM 50. 00 0 302, 801 0 9. 00 RECOVERY ROOM 51. 00 0 648 0 0 10. 00 RADIOLOGY-DIAGNOSTIC 54. 00 0 19, 259 0 11. 00 14. 280 PHYSICAL THERAPY 66. 00 0 321 0 0 12. 00 PHYSICAL THERAPY 66. 00 0 0 321 0 0 14. 400 PHYSICAL THERAPY 66. 00 0 1, 495 0 14. 00 PHYSICAL THERAPY 66. 00 0 1, 495 0 14. 00 PHYSICAL THERAPY 66. 00 0 1, 495 0 14. 00 PHYSICAL THERAPY 66. 00 0 0 30, 334 0 10 10 10 14. 00 PHYSICAL THERAPY 66. 00 0 0 10 10 10 10 11 10 10 10 11 10 10			•	0				4. 00
7. 00 ADULTS & PEDIATRICS 30. 00 0 1, 458 0 8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			•	0		1		5. 00
8. 00 OPERATING ROOM 50. 00 0 302,801 0 0 0 0 0 0 0 0 0		1		0				6. 00
9. 00 RECOVERY ROOM 51. 00 0 648 0 0 10. 00 RADI OLOGY - DI AGNOSTI C 54. 00 0 19, 259 0 0 11. 00 LABORATORY 60. 00 0 321 0 0 12. 00 PHYSI CAL THERAPY 66. 00 0 0 60, 910 0 13. 00 PHYSI CAL THERAPY 66. 00 0 0 1, 495 0 14. 00 MARKETI NG 194. 00 0 30, 334 0 0 TOTALS 0 691, 706 1 10. 163 834, 370 0 10. 10. 163 834, 370 0 10. 10. 163 834, 370 0 10. 163 834,		ı ı	•	0		1		7. 00
10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 19,259 0		I I	•	0		1		8. 00
11. 00 LABORATORY 60. 00 0 321 0 12. 00 PHYSI CAL THERAPY 66. 00 0 60, 910 0 13. 00 PHYSI CAL THERAPY 66. 00 0 1, 495 0 14. 00 MARKETI NG 194. 00 0 30, 334 0 TOTALS 0 0 691, 706 F F - MARKETI NG 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 110, 163 834, 370 0 G - CHI EF NURSI NG OFFI CER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 111, 816 77, 828 0 TOTALS 111, 816 77, 828 1 TOTALS 111, 816 71, 816 1 TOTALS 111, 8		I I	1	0		1		9. 00
12. 00 PHYSI CAL THERAPY 66. 00 0 60, 910 0 13. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 1, 495 0 14. 00 MARKETI NG 194. 00 0 30, 334 0 TOTALS 0 691, 706 F - MARKETI NG 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 110, 163 834, 370 0 TOTALS 110, 163 834, 370 0 G - CHI EF NURSI NG OFFI CER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 111, 816 77, 828 0 TOTALS 111, 816 77, 828 0 TOTALS 111, 816 77, 828 0 H - MEDI CAL SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 14, 580, 460 0 2. 00 OPERATI NG ROOM 50. 00 1220, 824 0 TOTALS 0 14, 801, 284 1 0 TOTALS 0 1, 255, 154 0 TOTALS 0 1, 255, 154 0 J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS 30 0 170 STRATI VE AVECAUSE SERVING SERV				0		1		10.00
13.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 1,495 0 144.00 MARKETING 194.00 0 30,334 0 TOTALS 0 691,706 F - MARKETING 110,163 834,370 0 TOTALS 111,816 77,828 0 TOTALS 111,816 TOTALS 111,		I I	•	0				11.00
14. 00 MARKETING		1	•	0	•			12.00
TOTALS		ı ı	I	0	•	1		13. 00
Totals	14.00		194.00	0				14. 00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 110, 163 834, 370 0 TOTALS 110, 163 834, 370 0 G - CHI EF NURSI NG OFFI CER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 111, 816 77, 828 0 TOTALS 111, 816 77, 828 0 H - MEDI CAL SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 14, 580, 460 0 2. 00 OPERATI NG ROOM 50. 00 220, 824 0 TOTALS 0 14, 801, 284 1 0 1 - DRUGS/I V SOLUTI ONS 1. 00 PHARMACY 15. 00 1, 255, 154 0 TOTALS 0 1, 255, 154 0 J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS 311, 944 22, 102				U	691, 706			
TOTALS	4 00		F 00	440 440	004 070			4 00
G - CHI EF NURSI NG OFFI CER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 111, 816 77, 828 0 TOTALS 111, 816 77, 828 0 H - MEDI CAL SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 14, 580, 460 0 COPERATI NG ROOM 50. 00 220, 824 0 TOTALS 0 14, 801, 284 0 I - DRUGS/I V SOLUTI ONS 1. 00 PHARMACY 15. 00 0 1, 255, 154 0 TOTALS 0 1, 255, 154 0 TOTALS 0 1, 255, 154 0 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 SPECH PATHOLOGY 68. 00 214 30 0 TOTALS 30 0 TOTALS 30 0 SPECH PATHOLOGY 68. 00 214 30 0 TOTALS 311, 944 22, 102	1.00							1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 111, 816 77, 828 0 TOTALS 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 111, 816 77, 828 1 11, 81				110, 163	834, 370)		
TOTALS H - MEDI CAL SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY OPERATI NG ROOM TOTALS OPERATING ROOM I - DRUGS/IV SOLUTI ONS 1. 00 PHARMACY TOTALS OPHARMACY TOTALS	1 00		F 00	111 01/	77.000			1 00
H - MEDI CAL SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 14, 580, 460 0 2. 00 OPERATI NG ROOM 50. 00 220, 824 0 TOTALS 0 14, 801, 284 1 1. 00 PHARMACY 15. 00 0 1, 255, 154 0 TOTALS 0 1, 255, 154 0 J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS 311, 944 22, 102	1.00							1.00
1. 00				111,810	11, 828)		
2. 00 OPERATING ROOM 50. 00 220, 824 0 TOTALS 0 14, 801, 284 1 0 14, 801, 284 1 0 14, 801, 284 1 0 14, 801, 284 1 1 - DRUGS/I V SOLUTIONS 1. 00 1, 255, 154 0 1, 255, 154	1 00		14.00	٥	14 500 4/0			1 00
TOTALS 0 14,801,284 I - DRUGS/I V SOLUTIONS 1. 00 PHARMACY 15. 00 0 1,255, 154 0 TOTALS 0 1,255, 154 0 J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311,730 22,072 0 2. 00 SPECH PATHOLOGY 68. 00 214 30 0 TOTALS 311,944 22,102				0				1.00
- DRUGS/I V SOLUTIONS	2.00							2. 00
1. 00 PHARMACY 15. 00 0 1, 255, 154 0 TOTALS 0 1, 255, 154 0 1, 255, 155, 155, 155, 155, 155, 155, 1				U	14, 801, 284			
TOTALS 0 1, 255, 154 J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS 311, 944 22, 102	1 00		15.00	٥	1 055 154			1 00
J - MI SC DEPTS 1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS	1.00							1.00
1. 00 OCCUPATI ONAL THERAPY 67. 00 311, 730 22, 072 0 2. 00 SPEECH PATHOLOGY 68. 00 214 30 0 TOTALS 311, 944 22, 102				U	1, 255, 154	<u> </u>		
2. 00 SPEECH PATHOLOGY 68. 0021430 0 TOTALS 311, 944 22, 102	1 00		(7.00	211 720	22.072			1 00
TOTALS 311, 944 22, 102		ı ı						1.00
	∠. 00							2. 00
V OTHER		K - OTHER		311, 944	22, 102	-		
1. 00 RECOVERY ROOM	1 00		51 00	1 320 427	422 E00			1.00
2. 00 ANESTHESI OLOGY				1, 320, 03/	•	1		2.00
70TALS 1, 328, 637 456, 680	2.00			1 320 627				2.00
	500 00							500. 00
1 1, 502, 500 25,417, 000 1	500.00	Joi and Total . Deci eases	I	1, 002, 000	25, 417, 000	1 1		1 300. 00

Provider CCN: 15-0168

| Peri od: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

				10) 12/31/201/	5/31/2018 12:	
			_	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ 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	3, 506, 775	416, 126	0	416, 126		3. 00
4.00	Building Improvements	11, 905, 709	1, 007, 624	0	1, 007, 624	303, 337	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)	15, 641, 330	1, 423, 750	0	1, 423, 750	314, 031	8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	15, 641, 330	1, 423, 750	0	1, 423, 750	314, 031	10. 00
		Ending Balance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES	_1				
1.00	Land	0	0				1. 00
2.00	Land Improvements	26, 765	0				2. 00
3.00	Buildings and Fixtures	3, 912, 207	0				3. 00
4.00	Building Improvements	12, 609, 996	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)	16, 751, 049	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	16, 751, 049	0				10.00

Health Financial Systems	UTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-					2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-7 Part II Date/Time Pre 5/31/2018 12:	pared: 17 pm
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
	9. 00	10. 00	11. 00	12.00	13. 00	

			30	DWWART OF CALL	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	79, 934	0	C	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 152, 571	0	C	0	0	2. 00
3.00	Total (sum of lines 1-2)	1, 232, 505	0	C	0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1. 00	CAP REL COSTS-BLDG & FLXT	0	79, 934				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 152, 571				2. 00
3.00	Total (sum of lines 1-2)	0	1, 232, 505				3. 00

Heal th	n Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet A-7 Part III Date/Time Prep 5/31/2018 12:	pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL	ENTERS 1, 345, 747	1 0	1, 345, 747	0. 086038	0	1. 00
2.00	CAP REL COSTS-BLDG & FTXT	14, 295, 583		14, 295, 583			2.00
3.00	Total (sum of lines 1-2)	15, 641, 330		15, 641, 330			3. 00
0.00	Trotal (Sam of Trites 12)		TION OF OTHER (F CAPITAL	0.00
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	1	(1, 020, 332		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0			1, 388, 612		2. 00
3. 00	Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	2, 408, 944	-13, 214	3. 00
			50	JIVIIVIARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (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 III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	70, 256	494, 317	7 0	1, 571, 691	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 614		0	1, 395, 226	2. 00
3.00	Total (sum of lines 1-2)	0	76, 870	494, 317	7 O	2, 966, 917	3. 00

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0168

Suppose Classal Floation on North-Sheet A \$731/2018 12 17 pp.						o 12/31/2017	Date/Time Prep	
Does Control Description Resist/Osda (2) Amount Cost Control Line # Most A-7 Ref.							3/31/2016 12.	i / piii
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 1.00								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 7.00								
Timusstant income - CAP REL OCAP REL COSTS-BLOG & FIXT 1.00 0 1.00		Cost Center Description						
Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 2.00 0 3.00	1. 00	II	1.00					1. 00
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
Chapter 2) 0	3 00			0		0.00	0	3 00
discounts (chapter 8)		(chapter 2)						
	4.00	di scounts (chapter 8)		0			0	4.00
Sentral or provider space by 0 0.00 0.6.00 0.00 0.6.00 0.0	5. 00			0		0.00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 22) Stations excluded) (chapter 23) Stations excluded) (chapter 24) Stations exclu	6.00	Rental of provider space by		0		0. 00	О	6. 00
21) 22	7.00	Tel ephone servi ces (pay	А	-11, 720	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
Chapter 21)		/ ` '						
Parking of (chapter 21)	8. 00	II	A	-23, 443	CAP REL COSTS-MVBLE EQUIP	2.00	9	8. 00
adjustment		Parking Lot (chapter 21)		0		0.00	_	
Chapter 23) Chapter 23) Chapter 24) Chapter 100	10. 00		A-8-2	-14, 661			0	10. 00
12.00 Related organization charactions (chapter 10) 13.00 Laundry and I linen service 0 0.00 0.00 0.13.00 15.00	11. 00	•		0		0.00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 0.00 0.14.00 0.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00	12. 00	Related organization	A-8-1	-3, 853, 974			0	12.00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 18.00 0 19.00 0	13. 00			0		0.00	0	13. 00
and others' 1.0 00 Sale of medical and surgical supplies to other than patients 17.00 Sale of frequency of the patients of the				0				
Supplies to other than		and others		0				
17. 00 Sale of drugs to other than patients 0 0.00	16.00			0		0.00	0	16.00
patients	17. 00	1.		0		0.00	0	17. 00
abstracts	18 00	pati ents		0		0.00	0	18 00
education (tuition, fees, books, etc.)		abstracts		0				
20. 00 Vending machines 0 0.00 0.00 0.00 1ncome from imposition of interest. Finance or penal ty charges (chapter 21) 1 11 11 12 12 10 11 11	19. 00			0		0.00	O	19.00
21.00	20. 00			0		0.00	0	20. 00
Charges (chapter 21) Chapter 14) Chapter 17) Chapter 18) Chapter 19) Chapter 21) Chapter 22) Chapter 23) Chapter 24)		Income from imposition of		0			-	
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & F		charges (chapter 21)						
Page	22. 00			0		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL A 5,886 CAP REL COSTS-BLDG & FIXT 1.00 9 26. 00 (CoSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL A -130,340 CAP REL COSTS-MVBLE EQUIP 2.00 9 27. 00 0 COSTS-MVBLE EQUIP 2.00 9 27. 00 0 COSTS-MVBLE EQUIP 2.00 9 27. 00 COSTS-MVBLE EQUIP 2.00 9 27. 00 0 COSTS-MVBLE EQUIP 2.00 9 27. 00 COSTS-MVBLE EQUIP 2.00 9 27. 0	22 00	repay Medicare overpayments		0	DESDIDATODY THEDADY	65.00		22 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	23.00	therapy costs in excess of	A-0-3	O	RESTRATORT THERAFT	03.00		23.00
limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL A 5,886 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00 COSTS-BLDG & FIXT 1.00 9 26.00 27.00 27.00 27.00 27.00 27.00 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29.00 2	24. 00		A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 25.00 26.00 26.00 26.00 26.00 27.00 27.00 27.00 27.00 27.00 28.00 29.00								
Chapter 21) Depreciation - CAP REL A 5,886 CAP REL COSTS-BLDG & FIXT 1.00 9 26.00	25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest A -130, 340 CAP REL COSTS-MVBLE EQUIP A -8-3 O NONPHYSICIAN ANESTHETISTS D -00 A -8-3 O OCCUPATIONAL THERAPY A -8-3 O ADULTS & PEDIATRICS A -8-3 O SPEECH PATHOLOGY A -8-3 O SPEECH PATHOLOGY A -8-3 O OCCUPATIONAL THERAPY		(chapter 21)						
28. 00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 Physicians' assistant O OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) OSPEECH PATHOLOGY OSPEECH	26. 00		A	5, 886	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
28.00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19.00 29.00 29.00 Physicians' assistant 0.00 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest	27. 00		A	-130, 340	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
30. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adj ustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67. 00 30. 00 A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 32. 00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 31. 00 31. 00 32. 00			A-8-3	0	OCCUPATI ONAL THERAPY		-	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OSPEECH PATHOLOGY 68.00 31.00 O O O O O O O O O O O O O O O O O O	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	33. 00		В	-13, 214	CAP REL COSTS-BLDG & FIXT	1.00	10	33. 00

From 01/01/2017 | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

5/31/2018	1 1 1 1
Expense Classification on Worksheet A	
To/From Which the Amount is to be Adjusted	
Cont. Contain Description Design(Code (C)). Amount Cont. Contain Design (Code (C)).	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 F	ег.
1.00 2.00 3.00 4.00 5.00	0 00 01
33. 01 CABLE EXPENSE A -8, 170 OPERATION OF PLANT 7. 00	0 33. 01
33. 02 INSERVICE EDUCATION B -50 NURSING ADMINISTRATION 13. 00	0 33. 02
33. 03 FI TNESS REVENUE B -100, 658 ADMI NI STRATI VE & GENERAL 5. 00	0 33. 03
34. 00 OTHER MISC REVENUE B -17, 609 ADMINISTRATIVE & GENERAL 5. 00	0 34.00
35. 00 MARKETING EXPENSES A -7, 300 ADMINISTRATIVE & GENERAL 5. 00	0 35.00
36. 00 LOBBYING EXPENSES A -300 ADMINISTRATIVE & GENERAL 5. 00	0 36.00
37. 00 PHYSICIAN RECURITING A -190, 171 ADMINISTRATIVE & GENERAL 5. 00	0 37.00
38. 00 LOBBYING EXPENSE A -2, 924 ADMINISTRATIVE & GENERAL 5. 00	0 38.00
39. 00 CHARI TABLE CONTRIBUTIONS A -38, 894 ADMINI STRATI VE & GENERAL 5. 00	0 39.00
40.00 HR - EVENT PLANNING A -2,767 EMPLOYEE BENEFITS DEPARTMENT 4.00	0 40.00
41. 00 PENALTIES A -2 ADMINISTRATIVE & GENERAL 5. 00	0 41.00
42. 00 LEGAL FEES A -8, 453 ADMI NI STRATI VE & GENERAL 5. 00	0 42.00
43.00 TELEPHONE - BENEFIT COST A -186 EMPLOYEE BENEFITS DEPARTMENT 4.00	0 43.00
44. 00 PHYSI CI AN GUARANTEES A -133, 333 ADMI NI STRATI VE & GENERAL 5. 00	0 44.00
45. 00 MI NORI TY I NTEREST A -19, 010, 651 ADMI NI STRATI VE & GENERAL 5. 00	0 45.00
50.00 TOTAL (sum of lines 1 thru 49) -23,562,934	50.00
(Transfer to Worksheet A,	
column 6, line 200.)	

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Worksheet A-8-1

Peri od: From 01/01/2017 OFFICE COSTS 12/31/2017 Date/Time Prepared:

					5/31/2018 12:	17 pm
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	l
	HOME OFFICE COSTS:					l
1.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL - BLDG & FIXTUR			1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	2, 408	0	2. 00
3.00		ADMINISTRATIVE & GENERAL	PASI OPERATING COST	126, 680	161, 459	
3. 01	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQ.	171, 201	0	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	1, 587, 517	555, 759	3. 02
3.03	5. 00	ADMINISTRATIVE & GENERAL	MALPRACTI CE	62, 696	57, 155	3. 03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	FWO SUGERY CENTER	355, 845	1, 361, 826	3. 04
3.05	1.00	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS MRI	13, 283	65, 176	3. 05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS PT	146, 687	444, 101	3. 06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	TOH RENT/LUTHERAN	447, 807	2, 421, 890	3. 07
3.08	8. 00	LAUNDRY & LINEN SERVICE	TOH LINEN	100, 969	116, 176	3. 08
3.09	5. 00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	1, 112, 749	3. 09
3. 10	5. 00	ADMINISTRATIVE & GENERAL	SSC ALLOCATION	0	354, 732	3. 10
3. 11	5. 00	ADMINISTRATIVE & GENERAL	HIIM ALLOCATION	0	254, 111	3. 11
3. 12	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	27, 464	O	3. 12
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			3, 051, 160	6, 905, 134	5. 00
	Transfer column 6, line 5 to					l
	Worksheet A-8, column 2,					l
	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	
		Ownershi p		Ownershi p	
 1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	COMMUNITY HEALT	60. 00 COMMUNI TY HI	EALT 60.00	6.00
7.00	В	LUTHERAN HEALTH	40. 00 LUTHERAN HEA	ALTH 40. 00	7.00
8. 00	В	HOSPI TAL LAUNDR	100.00 HOSPITAL LAI	UNDR 100. 00	8.00
9.00			0. 00	0.00	9.00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in
- provi der.

					10 12/01/201/	5/31/2018 12:	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO						
1. 00	8, 603						1.00
2.00	2, 408						2.00
3.00	-34, 779						3.00
3. 01	171, 201						3. 01
3. 02	1, 031, 758						3. 02
3.03	5, 541						3. 03
3.04	-1, 005, 981	9					3. 04
3.05	-51, 893	9					3. 05
3.06	-297, 414	9					3.06
3.07	-1, 974, 083	9					3. 07
3.08	-15, 207	0					3. 08
3.09	-1, 112, 749	0					3. 09
3. 10	-354, 732	0					3. 10
3. 11	-254, 111	0					3. 11
3. 12	27, 464	9					3. 12
4.00	0	0					4.00
5.00	-3, 853, 974						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.

 	cordinate i diagraf 2, the discourt direstable chedia se mandated in cordinat i or this parti	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.	6. 00
7.00	HEALTHCARE	7.	7. 00
8.00	HEALTHCARE		8. 00
9.00		9.	9. 00
10.00		10.	0. 00
100.00		100.	J. 00

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

Provider CCN: 15-0168

					'	12/31/201/	5/31/2018 12:	
	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	33, 508	0	33, 508	179, 000	219	1. 00
2.00	0. 00		0	0	0	0	0	2. 00
3.00	0.00		0	0	0	0	0	3. 00
4.00	0. 00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10. 00	0.00		0	0	0	0	0	10.00
200.00			33, 508	0	33, 508	_	219	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14.00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	18, 847	942	0	0	0	1. 00
2.00	0.00		0	0	0	0	0	2. 00
3.00	0.00		0	0	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	1
200.00			18, 847	942	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	18, 847	14, 661	14, 661		1. 00
2.00	0.00		0	0	0	0		2. 00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5. 00
6.00	0.00		0	0	0	0		6. 00
7. 00	0. 00		0	0	0	0		7. 00
8. 00	0.00		0	o o	0	o o		8. 00
9. 00	0. 00		l o	l 0	0	0		9. 00
10. 00	0. 00		l o	l o	0	Ö		10. 00
200.00	3, 00		l o	18, 847	14, 661	_		200. 00
200.00	1	ļ	1		, 551	, 001	ı	00.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168

				To	12/31/2017	Date/Time Pre 5/31/2018 12:	
			CAPITAL RELATED COSTS			3/31/2016 12.	17 pili
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		col. 7)	1.00	2.00	4.00	4.0	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 571, 691	1, 571, 691				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 395, 226		1, 395, 226	0.075.404		2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	2, 365, 491 9, 429, 931	0 47, 788		2, 365, 491 614, 679		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	1, 842, 289	353, 854	1	7, 319		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	81, 641	0	0	0		8. 00
9.00	00900 HOUSEKEEPI NG	415, 634	0	0	0	415, 634	9.00
10. 00 12. 00	01000 DI ETARY 01200 MAI NTENANCE OF PERSONNEL	272, 948	0	0	0	272, 948 0	10. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	840, 936	0	Ö	56, 504	897, 440	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 143, 951	89, 546	79, 492	75, 667	1, 388, 656	14. 00
15. 00	01500 PHARMACY	513, 352	0	0	32	513, 384	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	770, 874	0	0	1, 519 0	772, 393	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICES	0	0	Ö	0	Ö	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	0	0	0 0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	0	Ö	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 520, 490	217, 764 0		337, 736 0		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	o	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	0	0	40. 00 41. 00
43. 00	04300 NURSERY	0	0	ő	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	0	0	45. 00 46. 00
46.00	ANCI LLARY SERVI CE COST CENTERS	0	0	<u> </u>	U	0	40.00
50.00	05000 OPERATING ROOM	9, 777, 162	478, 593	424, 857	866, 082	11, 546, 694	50. 00
51.00	05100 RECOVERY ROOM	0	133, 893	1	0		51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0	0	0	0	0 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	398, 055	30, 674	27, 230	25, 274	481, 233	54. 00
54. 01	03630 ULTRA SOUND	3, 963	0	0	0	3, 963	54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0 0	55. 00 56. 00
	05600	3, 727	0	0	0	3, 727	
	05800 MRI	4, 701	0	Ö	0	4, 701	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	418, 369	0	0	622 0	418, 991 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	14, 455	0	0	0	0 14, 455	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 413, 423	219, 579		361, 361	3, 189, 289	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0 20 1/1	0	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	20, 161	0	0	0	20, 161 0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	636, 036	0	Ö	0	636, 036	•
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 165, 248	0	0	0	14, 165, 248	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 255, 154	0	0	0	1, 255, 154	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)		0	0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS		-		-		
	08800 RURAL HEALTH CLINIC	0	0		0	-	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0 0	89. 00 90. 00
91. 00	09100 EMERGENCY	0	Ö	Ŏ	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1				0	92. 00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168 Peri od: Worksheet B From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 0 94 00 0 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97 00 0 09850 OTHER REIMBURSABLE COSTS 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 000000 00000 106.00 10600 HEART ACQUISITION 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 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 ACQUISITION 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 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 52, 274, 908 1, 571, 691 1, 395, 226 52, 256, 212 118. 00 118.00 2, 346, 795 NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 14,836 0 138 14, 974 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 MARKETI NG 2, 803, 750 0 18, 558 2, 822, 308 194. 00

55, 093, 494

1, 571, 691

0

2, 365, 491

1, 395, 226

0 194. 01

0 200, 00

0 201.00

55, 093, 494 202. 00

194. 01 07951 SENI OR CIRCLE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0168

Peri od: Worksheet B From 01/01/2017 Part I Date/Time Prepared: 12/31/2017

5/31/2018 12:17 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 10.134.821 5 00 7.00 00700 OPERATION OF PLANT 567, 527 3, 085, 113 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 18, 404 100, 045 8.00 9.00 00900 HOUSEKEEPI NG 93, 694 509, 328 9.00 C 334, 477 01000 DI ETARY 10.00 10.00 61, 529 C 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 13 00 01300 NURSING ADMINISTRATION 202, 305 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 236, 109 313, 038 38, 980 14 00 0 14.00 15.00 01500 PHARMACY 115, 730 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 174, 117 0 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 0 0 01850 OTHER GENERAL SERVICES 0 18.00 0 C 0 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20 00 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 0 0 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 r 0 0 22 00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 574, 186 334, 477 30.00 736, 983 83, 012 94, 794 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 Λ 34 00 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 C 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 602, 913 1, 261, 924 17,033 208, 334 0 50.00 05100 RECOVERY ROOM 56, 977 58, 284 0 51.00 51.00 353.042 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 108, 482 80, 879 0 13, 352 0 54.00 54.01 03630 ULTRA SOUND 893 0 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 Ω 0 0 56.00 05600 RADI OI SOTOPE 0 C 0 0 0 56.00 05700 CT SCAN 840 0 57.00 57.00 0 0 58.00 05800 MRI 0 0 58.00 1,060 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 0 60.00 06000 LABORATORY 94, 451 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 3.259 0 0 65.00 0 66 00 06600 PHYSI CAL THERAPY 718, 945 578.973 95, 584 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY C 0 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 4, 545 C 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 143, 378 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 193, 213 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 282.943 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 0 0 90.00 09000 CLI NI C 0 0 90.00 0 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 0 09500 AMBULANCE SERVICES 0 0 C 95.00 95 00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0

0

0

0 97.00

0

98.00

09850 OTHER REIMBURSABLE COSTS

97.00

98 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0168

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/31/2018 12:17 pm ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 99. 00 09900 CMHC 99. 00 0 n 0 0 99. 10 99. 10 09910 CORF 0 C 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 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106. 00 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 0 0 0 0 108. 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 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111. 00 0 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 9, 495, 226 3, 085, 113 100, 045 509, 328 334, 477 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 0 190. 00 0 0 0 0 0 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 3, 376 0 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00 194. 00 07950 MARKETI NG 636, 219 0 0 0 194. 01 194. 01 07951 SENI OR CIRCLE 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 334, 477 202. 00 10, 134, 821 3, 085, 113 100, 045 509, 328

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/31/2018	12:17 pm

					12/31/201/	5/31/2018 12:	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON			RECORDS &	
		12. 00	13. 00	SUPPLY 14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS	12.00	13.00	14.00	13.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	4 000 745				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 099, 745	1 07/ 700			13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	0	1, 976, 783	629, 492		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	378	029, 492	946, 510	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	940, 310	17. 00
18. 00	01850 OTHER GENERAL SERVICES	0	Ö	Ö	Ö	0	18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	Ö	Ö	ol	0	19.00
20. 00	02000 NURSI NG SCHOOL	0	0	o	o	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	О	0	o	0	21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	302, 104	25, 634	0	20, 252	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	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	U	0	34.00
40. 00 41. 00	04100 SUBPROVIDER - I PF		0	0	0	0	40. 00 41. 00
43. 00	04300 NURSERY		0	0	0	0	43.00
44. 00	04400 SKI LLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	o o	Ö	Ö	Ö	0	46. 00
	ANCILLARY SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	-',		
50.00	05000 OPERATING ROOM	0	774, 478	333, 874	0	369, 268	50. 00
51.00	05100 RECOVERY ROOM	0	0	32, 346	o	57, 173	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 607	356	0	17, 824	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	240	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	U O	0 14	56. 00 57. 00
58. 00	05800 MRI		0	0	0	162	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	59.00
60. 00	06000 LABORATORY	0	556	9, 528	Ö	9, 664	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	ol	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				آ ا	_	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	О	0	o	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	934	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	10, 723	0	30, 442	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	836	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	00 (22	0	47.022	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	99, 623	U O	47, 032	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 464, 304	629, 492	289, 531 103, 138	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		0	0	029, 492	103, 138	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
. 5. 66	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>	0	. 5. 50
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O	o	ol	0	89. 00
90.00	09000 CLI NI C	0	0	0	o	0	90. 00
91. 00	09100 EMERGENCY	0	0	0	o	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
_	OTHER REIMBURSABLE COST CENTERS			T.			_
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00	09500 AMBULANCE SERVI CES	0	0		0	0	95.00
96. 00 97. 00	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD		0		0	0	96. 00 97. 00
71.00	101100 DOUVDER MEDICULE FROIL-20FD	١	ı	ı	Ч	U	77.00

| Period: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:

			Io	12/31/2017	Date/lime Pre 5/31/2018 12:	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, p
		ADMI NI STRATI ON			RECORDS &	
			SUPPLY		LI BRARY	
	12.00	13.00	14.00	15. 00	16. 00	
98. 00 09850 OTHER REIMBURSABLE COSTS	C	0	0	0	0	98. 00
99. 00 09900 CMHC	C	o	0	0	0	99. 00
99. 10 09910 CORF	C	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	C	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	C	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	C	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	C	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	C	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	C	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	C	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	C	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	C	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0	0	0		115. 00
116. 00 11600 HOSPI CE	C	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	1, 099, 745	1, 976, 766	629, 492	946, 510	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0		190. 00
191. 00 19100 RESEARCH	C	0	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	17	0		192. 00
193. 00 19300 NONPALD WORKERS	C	0	0	0		193. 00
194. 00 07950 MARKETI NG	C	0	0	0		194. 00
194. 01 07951 SENI OR CI RCLE	C	0	0	0	0	194. 01
200.00 Cross Foot Adjustments	_	_	_	_	_	200. 00
201.00 Negative Cost Centers	C	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	C	1, 099, 745	1, 976, 783	629, 492	946, 510	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/201 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168

				Т	o 12/31/2017	Date/Time Prep 5/31/2018 12:	
			OTHER GENERAL			INTERNS &	17 piii
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCIAL SERVICE	S		NURSING SCHOOL	SERVI CES-SALAR	
				ANESTHETI STS		Y & FRINGES APPRV	
		17. 00	18. 00	19. 00	20.00	21.00	
	GENERAL SERVICE COST CENTERS	1			1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY						15. 00
	01600 MEDI CAL RECORDS & LI BRARY						16.00
	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES	0	0				17.00
	01900 NONPHYSI CLAN ANESTHETI STS	0	0				18. 00 19. 00
	02000 NURSI NG SCHOOL	0	0		0		20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
23.00	02300 PARAMED ED PRGM	0	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	0	0				30. 00
	03100 NTENSI VE CARE UNI T	0	0				31.00
	03200 CORONARY CARE UNIT	0	0		-	0	32. 00
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	1	ŭ	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF	0	0	1 0	0	0	40.00
	04100 SUBPROVI DER - I RF	0	0	Ö	0	Ö	41. 00
	04300 NURSERY	0	0		Ö	Ö	43. 00
	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
45.00	04500 NURSING FACILITY	0	0	C	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	_		Г .			
	05000 OPERATING ROOM	0	0				50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	51. 00 52. 00
	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	Ö	0	0	54. 00
	03630 ULTRA SOUND	0	0	C	Ö	Ō	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	C	0	0	56. 00
57.00	05700 CT SCAN	0	0	C	0	0	57. 00
58. 00	05800 MRI	0	0	C	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	07.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0	0	60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0		60. 01 61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	o	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	i c	Ö	Ö	63. 00
	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	n n	0	n		73. 00
	07400 RENAL DIALYSIS	0	0		o o	Ö	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	c	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS	,					
	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
	09000 CLI NI C	0	0	0	0	0	90.00
	09100 EMERGENCY	0	0	C	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	С	0	0	94. 00
	09500 AMBULANCE SERVI CES	0					
		•			•	- '	·

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/201

			'	0 12/31/201/	5/31/2018 12:	
		OTHER GENERAL			INTERNS &	
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE	S	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	
			ANESTHETI STS		Y & FRINGES	
					APPRV	
	17. 00	18. 00	19. 00	20.00	21. 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	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		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	C	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		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 ISLET ACQUISITION	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	C	0	0	115. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	0	0	118. 00
NONRE 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 PHYSICIANS' PRIVATE OFFICES	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	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	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	[C	0	0	202. 00

Un Lieu of Form CMS-2552-10
Worksheet B
D1/2017 Part |
B1/2017 Date/Time Prepared:
5/31/2018 12: 17 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS LUTHERAN MUSCULOSKELETAL CENTER Peri od: From 01/01/2017 To 12/31/2017 Provider CCN: 15-0168

	Cost Center Description	INTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	, , , , , , , , , , , , , , , , , , ,
	GENERAL SERVICE COST CENTERS	22. 00	23. 00	24. 00	25. 00	26. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	C				1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0 0 0 0 0 0 0 0			0 0 0 0 0 0	5, 440, 746 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
	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06000 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06900 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		810, 575 0 724, 733 5, 096 0 0 4, 581 5, 923 0 533, 190 0 0 0 0 18, 648 4, 623, 956 0 0 25, 542 0 926, 069 19, 112, 296 2, 270, 727 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 533, 190 0 0 0 0 18, 648 4, 623, 956 0 25, 542 0 926, 069 19, 112, 296 2, 270, 727 0	54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00
88. 00 89. 00 90. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 0 0	C C C	0 0 0	o	0 0 0 0	88. 00 89. 00 90. 00 91. 00 92. 00

Health Financial Systems	LUTHEI	RAN MUSCULOSI	KELETAL CENTER	?	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COST	S		Provi der Co	CN: 15-0168	Period: From 01/01/2017	Worksheet B Part I	
					To 12/31/2017	Date/Time Pre	pared:
						5/31/2018 12:	17 pm
		NTERNS & RESI DENTS					
Cost Center Description		VI CES-OTHER	PARAMED ED	Subtotal	Intern &	Total	
0001 0011101 00001 1 111 011		RGM COSTS	PRGM	ous to tu.	Residents Cost		
		APPRV			& Post		
					Stepdown		
		22. 00	23. 00	24. 00	Adjustments 25.00	26. 00	
OTHER REIMBURSABLE COST CENTERS		22.00	23.00	24.00	25.00	26.00	
94. 00 09400 HOME PROGRAM DIALYSIS		0	0		0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		o	0		0 0	o o	
96. 00 09600 DURABLE MEDICAL EQUIP-RENT	ED	o	0		0 0	Ö	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		O	0		0 0	O	1
98.00 09850 OTHER REIMBURSABLE COSTS		o	0		0 0	0	98. 00
99. 00 09900 CMHC		0	0		0 0	0	
99. 10 09910 CORF		0	0		0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PR	:GM	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		O		Γ	0 0	0	105. 00
106. 00 10600 HEART ACQUISITION		0	0				106.00
107. 00 10700 LI VER ACQUI SI TI ON		0	0				107.00
108.00 10800 LUNG ACQUISITION		o	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION		o	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION		О	0		0 0	0	110.00
111.00 11100 ISLET ACQUISITION		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		115.00
116. 00 11600 HOSPI CE	through 117)		0	E1 /1/ //	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 NONREIMBURSABLE COST CENTERS	through 117)	0	0	51, 616, 60	00 0	51, 616, 600	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	a omitteen	Ö	0		0 0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CE	S	o	0	18, 36	57 0		192. 00
193.00 19300 NONPALD WORKERS		О	0		0 0	0	193. 00
194. 00 07950 MARKETI NG		o	0	3, 458, 52	27 0	3, 458, 527	
194. 01 07951 SENI OR CI RCLE		O	0		0 0		194. 01
200.00 Cross Foot Adjustments		0	0		0		200. 00
201.00 Negative Cost Centers		0	0		0 0		201. 00
202.00 TOTAL (sum lines 118 throu	gh 201)	0	0	55, 093, 49	94 0	55, 093, 494	202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			Ť	o 12/31/2017	Date/Time Pre 5/31/2018 12:	
		CAPI TAL RE	LATED COSTS		3/31/2010 12.	I / DIII
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
2000 20000 20000 40000	Assi gned New				BENEFI TS	
	Capi tal Rel ated Costs				DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS		T	I			1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP			•			1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	O	0	0	0	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	0	47, 788 353, 854			0	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	353, 854	314, 124 0	667, 978 0	0	8.00
9. 00 00900 HOUSEKEEPI NG	0	O	0	0	0	9. 00
10. 00 01000 DI ETARY	0	0	0	0	0	10.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON			0	0	0	12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	89, 546	79, 492	169, 038	0	14. 00
15. 00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	0		0	0	0	16. 00 17. 00
18. 00 01850 OTHER GENERAL SERVICES	0	o o	Ö	Ö	0	18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I&R SERVI CES-SALARY & FRI NGES	APPRV	0	0	0	0	20. 00 21. 00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS		Ö	ő	0	0	22. 00
23. 00 02300 PARAMED ED PRGM	0	C	0	0	0	23. 00
30.00 INPATIENT ROUTINE SERVICE COST CENT	ERS 0	217, 764	193, 314	411, 078	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0	0	Ö	31.00
32. 00 03200 CORONARY CARE UNIT	0	O	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	O	0	0	0	41. 00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0		0	0	0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	0	Ö	Ö	0	0	46. 00
ANCILLARY SERVICE COST CENTERS		1 470 500	101.057	000 450		
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	0				0	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		133, 073	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0	30, 674	27, 230	57, 904	0	54. 00 54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C			0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	o o	Ō	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON			0	0	0	58. 00 59. 00
60. 00 06000 LABORATORY	Ö	Ö	Ö	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGI 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOI				0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TI	4		Ö	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	O	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	210 570	104 024	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		219, 579	194, 926 0	414, 505 0	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	Ö	Ö	Ö	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	ATIENT 0	0	0	0	0	70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o o	Ō	0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		<u> </u>	u 0	0	0	75. 00
88.00 08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CEI	NTER 0	0	0	0	0	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0		0	0	0	90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINC	T PART	<u> </u>	<u> </u>	0		92.00
OTHER REIMBURSABLE COST CENTERS						04.00
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			To	12/31/2017	Date/Time Pre 5/31/2018 12:	
		CAPI TAL REI	ATED COSTS		3/31/2010 12.	T7 pill
		07.11 17.12 11.22	21125 00010			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	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	
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						1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105. 00
106.00 10600 HEART ACQUISITION	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 I NTESTI NAL ACQUI SI TI ON	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 I NTEREST 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 through 117)	0	1, 571, 691	1, 395, 226	2, 966, 917	0	118. 00
NONREI MBURSABLE COST CENTERS				ما		100 00
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	0	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	0	0	0	0	194. 01
200.00 Cross Foot Adjustments		^		0	^	200.00
201.00 Negative Cost Centers		0	1 205 204	0 0// 017		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	1, 571, 691	1, 395, 226	2, 966, 917	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0168

Peri od: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Pre

Date/Time Prepared: 5/31/2018 12:17 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 90 211 5 00 7.00 00700 OPERATION OF PLANT 5,053 673, 031 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 164 164 8.00 9.00 00900 HOUSEKEEPI NG 834 C 834 9.00 01000 DI ETARY 0 548 10.00 10.00 548 C 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13 00 01300 NURSING ADMINISTRATION 1,801 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 2.787 51, 508 0 14 00 0 15.00 01500 PHARMACY 1,030 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,550 0 16.00 01700 SOCIAL SERVICE 17.00 17.00 0 0 01850 OTHER GENERAL SERVICES 0 18.00 C 0 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 0 0 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22 00 0 r 0 22 00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 548 30.00 6,561 125, 261 136 155 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 Λ 34 00 0 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 0 0 0 0 0 41.00 04300 NURSERY 0 0 43.00 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 C 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 174 275, 294 28 341 0 50.00 05100 RECOVERY ROOM 507 77, 018 0 0 51.00 51.00 95 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 0 0 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 966 17,644 0 22 0 54.00 54.01 03630 ULTRA SOUND 8 0 0 0 0 0 0 0 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55 00 Ω 0 0 56.00 05600 RADI OI SOTOPE 0 C 0 56.00 05700 CT SCAN 7 0 57.00 57.00 58.00 05800 MRI 9 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59 00 59 00 0 60.00 06000 LABORATORY 841 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 C 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 0 65.00 29 0 65.00 06600 PHYSI CAL THERAPY 66 00 6.401 126, 306 0 157 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 40 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 277 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 28, 411 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2.519 0 0 73.00 0 0 74.00 07400 RENAL DIALYSIS C 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 0 0 0 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 09500 AMBULANCE SERVICES 0 0 0 C 95.00 95 00 0 96.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 97.00

0

0 98.00

98 00

09850 OTHER REIMBURSABLE COSTS

| Period: | Worksheet B | From 01/01/2017 | Part II | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			To	o 12/31/2017	Date/Time Prepared: 5/31/2018 12:17 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
0001 001101 20001 ptron	& GENERAL	PLANT	LINEN SERVICE	HOUGENEEL THO	51211111
	5. 00	7. 00	8.00	9. 00	10. 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 ACQUISITION	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 INTESTINAL ACQUISITION	0	0	0	0	0 110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113. 00 11300 I NTEREST 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 through 117)	84, 517	673, 031	164	834	548 118. 00
NONREI MBURSABLE COST CENTERS		0		ما	0 100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	0	0 190. 00 0 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	30	0	0	0	0 191.00
193. 00 19300 NONPALD WORKERS	30	0	0	0	0 192.00
194. 00 07950 MARKETI NG	5, 664	0	0	0	0 193.00
194. 01 07951 SENI OR CI RCLE	3,004	0	0	0	0 194.00
200.00 Cross Foot Adjustments		O	J	O	200.00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	90, 211	673, 031	164	834	548 202. 00
	7072	0,0,00.		00.1	0.10 202.100

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2017 | Part II |
| To | 12/31/2017 | Date/Time Prepared: | 5/31/2018 | 12:17 pm

				10	12/31/2017	5/31/2018 12:	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		12. 00	13. 00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0					12. 00
13.00	01300 NURSING ADMINISTRATION	0	1, 801				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	223, 397			14. 00
15. 00	01500 PHARMACY	0	0	43	1, 073		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	1, 550	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00 19. 00	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	Ö	0	l o	o	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	O	0	22. 00
23.00	02300 PARAMED ED PRGM	0	0	0	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	495	2, 897	0	31	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	0	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	U O	0	33. 00 34. 00
40. 00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43. 00	04300 NURSERY	o	0	o	o	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	Ö	Ö	0	44. 00
45.00	04500 NURSING FACILITY	0	0	О	О	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	1, 268	37, 731	0	677	50.00
51.00	05100 RECOVERY ROOM	0	0	3, 655	0	87	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	37	40	0	27	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0	0	O	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0	0	o	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MRI	0	0	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	1	1, 077	0	15 0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		U	۷	٥	U	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	o	o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1, 212	0	46	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	O O	1	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11, 258	0	71	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	165, 482	0	438	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	1, 073	156	73. 00
74.00	07400 RENAL DIALYSIS	O	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	o	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
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	89. 00
90.00	09000 CLI NI C	0	0		O	0	90.00
91. 00 92. 00	09100 EMERGENCY		0		O	0	91. 00 92. 00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						J 9∠. UU
94. 00	09400 HOME PROGRAM DIALYSIS		n	n	n	0	94. 00
95. 00	09500 AMBULANCE SERVICES	l ol	0		ol	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0	o	ō	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	О	0	97. 00
-							

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

			То	12/31/2017	Date/Time Pre 5/31/2018 12:	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	.,
· ·	PERSONNEL	ADMI NI STRATI ON	SERVICES &		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	
99. 00 09900 CMHC	0	0	0	0	0	, ,, ,,
99. 10 09910 CORF	0	0	0	0	0	99. 10
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 ACQUISITION	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 ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 I NTEREST 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 through 117)	0	1, 801	223, 395	1, 073	1, 550	118. 00
NONREI MBURSABLE COST CENTERS	T					
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	2	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 through 201)	0	1, 801	223, 397	1, 073	1, 550	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

				Τ̈́	o 12/31/2017	Date/Time Pre 5/31/2018 12:	
			OTHER GENERAL			I NTERNS &	17 pili
	Coot Conton Decemintion	COCLAL CEDVICE	SERVI CE	MONDHIVELCLAN	MILIDEL NC CCHOOL	RESI DENTS	
	Cost Center Description	SOCIAL SERVICE	S	ANESTHETI STS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	
						APPRV	
	GENERAL SERVICE COST CENTERS	17. 00	18. 00	19. 00	20.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 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						12. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & 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		0				17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		ő	C)		19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0			0	21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM		0				22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS						23.00
30.00	03000 ADULTS & PEDIATRICS	0	0				30. 00
31.00	03100 NTENSIVE CARE UNIT	0	0				31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0				32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		Ö				34.00
40.00	04000 SUBPROVI DER - I PF	0	О				40. 00
41.00	04100 SUBPROVI DER - I RF	0	0				41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		0				43. 00 44. 00
45. 00	04500 NURSING FACILITY		Ö				45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0				46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	0			Γ	50. 00
51. 00	05100 RECOVERY ROOM		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 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	0				54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C		0				55. 00
56. 00	05600 RADI OI SOTOPE	0	Ō				56. 00
57. 00	05700 CT SCAN	0	0				57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0				58.00
60.00	06000 LABORATORY		0				59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.		0				62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		Ö				64. 00
65.00	06500 RESPI RATORY THERAPY	0	О				65. 00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		Ö				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0				72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		ő				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
00 00	OUTPATIENT SERVICE COST CENTERS						00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0				88. 00 89. 00
90.00	09000 CLINIC		Ö				90.00
91.00	09100 EMERGENCY	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				94. 00
	09500 AMBULANCE SERVICES						95. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

OTHER GENERAL SERVICE S					0 12/31/201/	5/31/2018 12:	
Cost Center Description			OTHER GENERAL				77 5111
ANESTHETISTS			SERVI CE				
17.00	Cost Center Description	SOCIAL SERVICE	S	NONPHYSICI AN	NURSI NG SCHOOL	SERVI CES-SALAR	
17.00				ANESTHETI STS		Y & FRINGES	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 97.00 09700 09700 09700 09700 09700 09700 09700 09850 0716FR REI MBURSABLE COSTS 0 0 0 0 99.00 99.00 09900 09000							
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 98. 00 998. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 98. 00 99. 10 00. 00 100. 00		17. 00	18. 00	19. 00	20. 00	21. 00	
98. 00 09850 OTHER REIMBURSABLE COSTS 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 101. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 107. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 107. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 108. 00 10800 LUVER ACQUI SI TI ON 0 0 0 108. 00 10800 LUVER ACQUI SI TI ON 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 113. 00 11300 INTEREST EXPENSE 111. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 116. 00 10600 CONDITION 0 0 117. 00 11900 BUSTOALS (SUM OF LI NES 1 through 117) 0 0 0 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194. 00 1979S MARKETI ING 0 0 0 194. 00 1979S MARKETI ING 0 0 0 194. 00 1979S MARKETI ING 0 0 0 194. 01 1079S MARKETI ING 0 0 0 195. 01 1079S MARKETI ING 0 0		0	0				
99. 00 09900 CMHC 09910 CORF 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 0 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 105. 00 10500 KI DINEY ACQUI SI TI ON 0 0 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 101. 00 10100 INTERSIT INAL ACQUI SI TI ON 0 0 0 101. 00 10100 INTERSIT NAL ACQUI SI TI ON 0 0 0 111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 113. 00 1300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTIL ZATI ON REVI EW-SNF 113. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 116. 00 10600 HOSPI CE 0 0 0 116. 00 10900 PANSITALS (SUM OF LI NES 1 through 117) 0 0 0 0 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 0 0 0 119. 00 19000 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 191. 00 19000 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 191. 00 19000 NONPAID WORKERS 0 0 0 194. 00 07950 MARKETI NG 0 0 194. 00 07950 MARKETI NG 0 0 194. 00 07950 MARKETI NG 0 0 194. 01 07951 SENI OR CI RCLE 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
99. 10 09910 CORF 0 0 0 0 99. 10 100. 00 100. 01 100. 00		0	0				
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS		0	0				
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SITION 0 0 0 105. 00 10500 KI DNEY ACQUI SITION 0 0 0 106. 00 106. 00 107. 00 10700 LI VER ACQUI SITION 0 0 0 0 107. 00 108. 00 109. 00 10800 LUNG ACQUI SITION 0 0 0 0 109. 00		0	0				
105. 00 10500 KI DNEY ACQUI SI TI ON		0	0				101. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 10700 LIVER ACQUISITION 0 0 0 0 0 0 10700 LIVER ACQUISITION 0 0 0 0 0 0 10900 LUNG ACQUISITION 0 0 0 0 0 0 10900 LUNG ACQUISITION 0 0 0 0 0 10900 ANCREAS ACQUISITION 0 0 0 0 0 10900 ANCREAS ACQUISITION 0 0 0 0 0 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 111. 00 111. 00 111. 00 111. 00 111. 00 1SLET ACQUISITION 0 0 0 0 0 0 111. 00 1		1		T			405 00
107. 00 10700 LI VER ACQUI SI TI ON		0	0				
108. 00 10800 LUNG ACQUISITION 0 0 0 0 10900 PANCREAS ACQUISITION 0 0 0 0 10900 PANCREAS ACQUISITION 0 0 0 10900 PANCREAS ACQUISITION 0 0 0 0 10900 PANCREAS ACQUISITION 0 0 0 0 111. 00 11100 11100 INTESTI NAL ACQUISITION 0 0 0 0 111. 00 11100 INTEREST EXPENSE 1113. 00 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 MBBULATORY SURGICAL CENTER (D. P.) 0 0 0 116. 00 116. 00 HOSPICE 0 0 0 0 116. 00 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 193. 00 194. 00		0	0				
109. 00 10900 PANCREAS ACQUISITION 0 0 0 110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 1110. 00 0 0 0		0	0				
110.00 11000 INTESTINAL ACQUISITION 0 0 0 1110.00		0	0				
111. 00 11100 1 SLET ACQUI SI TI ON		0	0				
113.00		0	0				
114.00		U	U				
115. 00							
116. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 193. 00 19300 NONPAI D WORKERS 0 0 194. 00 07950 MARKETI NG 0 0 194. 01 07951 SENI OR CI RCLE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 118. 00		0	0				
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 192. 00 192. 00 193.		0	0				
190. 00	, , ,	U	U) U	U	110.00
191.00 19100 RESEARCH		0	0				190 00
192. 00		0	0				
193. 00 19300 NONPAI D WORKERS 0 0 0 194. 00 194. 00 194. 00 194. 01 07951 SENI OR CI RCLE 0 0 0 194. 01 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00		0	0				
194. 00 07950 MARKETING 0 0 0 194. 00 194. 01 07951 SENI OR CIRCLE 0 0 0 194. 01 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		0	0				
194. 01 07951 SENI OR CIRCLE 0 0 194. 01 200. 00 Cross Foot Adjustments 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00		0	0				
200.00 Cross Foot Adjustments 0		0	0				
201.00 Negative Cost Centers 0 0 0 0 0 201.00			_	l	o	0	
	· · · · · · · · · · · · · · · · · · ·	0	0	1 6	o		
202.00 101/12 (34/11 11/103 110 till 04gli 201) 0 0 0 0 0 202.00	202.00 TOTAL (sum lines 118 through 201)	0	0		0		202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168 Peri od: Worksheet B From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/31/2018 12:17 pm INTERNS & **RESI DENTS** SERVI CES-OTHER PARAMED ED Subtotal Intern & Total Cost Center Description PRGM COSTS **PRGM** Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10 00 10 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICES 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING SCHOOL 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 547, 162 547, 162 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVIDER - IRF 0 0 0 41.00 41.00 0 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 44 00 Λ 0 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 241, 963 1, 241, 963 0 50.00 51.00 05100 RECOVERY ROOM 334, 115 0 334, 115 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 53 00 0 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 76,640 76,640 54.00 54.01 03630 ULTRA SOUND 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 05600 RADI OI SOTOPE 56 00 0 0 56 00 57.00 05700 CT SCAN 57.00 05800 MRI 9 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION C 0 59.00 1, 934 1, 934 60.00 06000 LABORATORY 60 00 60.01 06001 BLOOD LABORATORY 0 0 60.01 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 30 0 30 65.00 06600 PHYSI CAL THERAPY 548, 627 66.00 548, 627 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 41 41 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12,606 0 12, 606 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 194, 331 194, 331 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 748 73.00 3, 748 73.00 0 74.00 07400 RENAL DIALYSIS C 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 0 91.00 91.00 0 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

Health Financial Systems	JTHERAN MUSCULOS	KELETAL CENTE	R	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/31/2018 12:	epared: 17 pm
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	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	C	94.00
95. 00 09500 AMBULANCE SERVICES				0	C	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED				0	C	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				0 0	C	
98. 00 09850 OTHER REIMBURSABLE COSTS				0	C	
99. 00 09900 CMHC				0	C	
99. 10 09910 CORF				0	C	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY				0 0	C	100.00
SPECIAL PURPOSE COST CENTERS			1	U U		101.00
105. 00 10500 KI DNEY ACQUISITION				0 0		105.00
106. 00 10600 HEART ACQUISITION				0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON				0 0		107.00
108. 00 10800 LUNG ACQUISITION				0 0		108.00
109. 00 10900 PANCREAS ACQUISITION				0 0	C	109.00
110.00 11000 INTESTINAL ACQUISITION				0 0	C	110.00
111.00 11100 ISLET ACQUISITION				0 0	C	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				0		115. 00
116. 00 11600 HOSPI CE				0 0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	C	2, 961, 2	21 0	2, 961, 221	1118. 00
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				32 0		192.00
193. 00 19300 NONPALD WORKERS			,	0 0		193.00
194. 00 07950 MARKETI NG			5, 60	54		194.00
194. 01 07951 SENI OR CI RCLE						194. 01
200.00 Cross Foot Adjustments	o	C		0 0		200.00
201.00 Negative Cost Centers	0	C		0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	C	2, 966, 9	17 0	2, 966, 917	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 LUTHERAN MUSCULOSKELETAL CENTER Provider CCN: 15-0168 Period: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/31/2018 12:17 pm CAPITAL RELATED COSTS

		CAPITAL RELATED COSTS		·			
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	·	(SQUARE FEET)	(DOLLAR VALUE)			& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
	CENEDAL CEDVICE COCT CENTEDS	1.00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT	123, 793					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1.207.70	123, 793				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	3, 764 27, 871		1		44, 958, 673 2, 517, 586	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	27,071	27,071	1		81, 641	8. 00
9. 00	00900 HOUSEKEEPI NG	0	0	0	0	415, 634	9. 00
10. 00 12. 00	1 1	0	0	0	0	272, 948 0	10. 00 12. 00
13. 00	1 1		0	335, 417	0	897, 440	13. 00
14. 00	1 I	7, 053	7, 053	1		1, 388, 656	
15.00		0	0			513, 384	15. 00
16. 00 17. 00	1 1		0	9, 016 0		772, 393	16. 00 17. 00
18. 00	1 1	0	Ö	Ö	0	Ö	18. 00
19.00	1	0	0	0	0	0	19. 00
20. 00 21. 00	ł ł	0	0	0	0	0	20. 00 21. 00
22. 00			Ö	Ö	0	Ö	22. 00
23. 00		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	17, 152	2, 004, 869	0	3, 269, 304	30. 00
31. 00	1 1	17, 132	17, 132	1	0	0	31. 00
32. 00		0	0	0	0	0	32. 00
33. 00 34. 00		0	0	0	0	0	33. 00 34. 00
40. 00	1 1		0		0		40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00		0	0	0	0	0	43. 00
44. 00 45. 00	1 I		0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	27 (0)	27 (0)	F 141 01E	0	11 544 404	FO 00
50. 00 51. 00	1 1	37, 696 10, 546				11, 546, 694 252, 753	50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
53. 00 54. 00		0	0	0 150, 031	0	401 222	53.00
54. 00	1 I	2, 416	2, 416 0	150, 031	0	481, 233 3, 963	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	O	0	0	55. 00
56.00	1	0	0	0	0	0	56. 00
57. 00 58. 00	ł ł		0	0	0	3, 727 4, 701	57. 00 58. 00
59. 00		0	0	0	0	0	
60.00	1 1	0	0	3, 691	0	418, 991	
60. 01 61. 00	1 1		0		0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
63.00		0	0	0	0	0	63. 00
64. 00 65. 00			0		0	0 14, 455	64. 00 65. 00
66. 00		17, 295	17, 295	2, 145, 112	0	3, 189, 289	
67. 00	1 1	0	0	0	0	0	67. 00
68. 00 69. 00	1 1	0	0	0	0	0 20, 161	68. 00 69. 00
70. 00	1 1		Ö	Ö	0	20, 101	70. 00
71. 00	1 1	0	0	0	0	636, 036	
72. 00 73. 00	1 1	0	0	0	0	14, 165, 248 1, 255, 154	
74. 00	1 1		0	Ö	0	1, 255, 154	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0	0	88. 00
89.00	1 1		0	•	0	0	89. 00
90. 00	09000 CLI NI C	0	0		0	0	90. 00
91. 00 92. 00	ł ł	0	0	0	0	0	91. 00 92. 00
7∠. UU	103200 003ENVATION DEUS (NON-DISTINCI PARI	1	I	I	I	I	7∠. UU

			To	12/31/2017	Date/Time Prepar 5/31/2018 12:17	red:
	CAPITAL REL	ATED COSTS			3/31/2018 12.17	рііі
Cost Center Description	BLDG & FLXT (SQUARE FEET) (MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5. 00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0		4. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0		5. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		6. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0		7. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0		8. 00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0	0	0		9. 00 9. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0 10	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 10	
SPECIAL PURPOSE COST CENTERS	<u> </u>	U	U	<u> </u>	010	1.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	ol	0 10!	5 00
106. 00 10600 HEART ACQUISITION	0	0	0	ol	0 100	
107. 00 10700 LIVER ACQUISITION	o	0	Ö	ol	0 10	
108. 00 10800 LUNG ACQUISITION	o	0	Ö	ol	0 108	
109. 00 10900 PANCREAS ACQUISITION	0	0	0	o	0 109	9. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0 110	0. 00
111.00 11100 ISLET ACQUISITION	0	0	0	o	0 11	1. 00
113.00 11300 INTEREST EXPENSE					11:	3. 00
114.00 11400 UTILIZATION REVIEW-SNF						4. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 11!	5. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 110	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 123, 793	123, 793	13, 931, 020	-10, 134, 821	42, 121, 391 118	8. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0 190	
191. 00 19100 RESEARCH	0	0	0	0	0 19	
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	0	0	817	0	14, 974 192	
193. 00 19300 NONPALD WORKERS 194. 00 07950 MARKETI NG	0	0	110 143	0	0 193 2, 822, 308 194	
194. 01 07951 SENI OR CI RCLE	0	0	110, 163	0	0 194	
200.00 Cross Foot Adjustments		O	J	ď		0. 00
201.00 Negative Cost Centers						1. 00
202.00 Cost to be allocated (per Wkst. B,	1, 571, 691	1, 395, 226	2, 365, 491		10, 134, 821 202	
Part I)	1,0,1,0,1	1,070,220	2,000,171		107 10 17 02 1 20	2.00
203.00 Unit cost multiplier (Wkst. B, Part I) 12. 696122	11. 270637	0. 168458		0. 225425 203	3. 00
204.00 Cost to be allocated (per Wkst. B,			0		90, 211 204	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 000000		0. 002007 209	5. 00
206.00 NAHE adjustment amount to be allocate (per Wkst. B-2)	d				200	6. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					20	7. 00

				'	0 12/31/201/	Date/lime Pre 5/31/2018 12:	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7. 00	8. 00	9. 00	10.00	12. 00	
1. 00 2. 00 4. 00 5. 00 7. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	92, 158					1. 00 2. 00 4. 00 5. 00
8. 00 9. 00 10. 00 12. 00 13. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	92, 138 0 0 0 0	137, 775 0 0 0 0	92, 158 0 0 0	15, 496 0 0	0	7. 00 8. 00 9. 00 10. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	7, 053 0 0 0 0 0	0 0 0 0 0	7, 053 0 0 0 0 0		0 0 0 0 0	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
20. 00 21. 00 22. 00 23. 00 30. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 17, 152	-	0 0 0 0	23. 00
31. 00 32. 00 33. 00 34. 00 40. 00 41. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0 0 0	0 0 0 0	0 0 0	0 0 0	0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00
43. 00 44. 00 45. 00 46. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0	0 0 0 0	0 0 0	0 0 0	0 0 0	43. 00 44. 00 45. 00 46. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01	O5000 OPERATING ROOM O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESIOLOGY O5400 RADIOLOGY-DIAGNOSTIC O3630 ULTRA SOUND	37, 696 10, 546 0 0 2, 416	23, 456 0 0 0 0 0	37, 696 10, 546 0 0 2, 416	0 0 0	1	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01
55. 00 56. 00 57. 00 58. 00 59. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 0	0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	0 0 0 0 0	
60. 01 61. 00 62. 00 63. 00 64. 00 65. 00	06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 0 0	0 0 0	0 0 0	0 0 0 0	0 0 0	00.00
70. 00 71. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	17, 295 0 0 0 0	0 0 0 0 0	17, 295 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0 0 0 0	0 0 0 0	0 0 0	0 0 0 0	0 0 0 0	75. 00
89. 00 90. 00 91. 00	08900 RORAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 0 0	0 0 0	000000000000000000000000000000000000000	0 0 0	0 0 0	88.00 89.00 90.00 91.00 92.00
94. 00 95. 00 96. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0 0 0	0 0 0	0	_	_	95. 00

				0 12/31/201/	5/31/2018 12:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF	
· · · · · · · · · · · · · · · · · · ·	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	PERSONNEL	
	(SQUARE FEET)	(POUNDS OF	SERVICE)	` ´	(NUMBER	
	,	LAUNDRY)			HOUSED)	
	7. 00	8. 00	9. 00	10.00	12. 00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	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	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0		C	٦		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		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 through 117)	92, 158	137, 775	92, 158	15, 496	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191. 00
192.00 19200 PHYSI CLANS' 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	C	0		194. 00
194. 01 07951 SENI OR CI RCLE	0	0	C	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)	3, 085, 113	100, 045	509, 328	334, 477	0	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	33. 476345	0. 726148	5. 526682	21. 584732	0. 000000	203. 00
204.00 Cost to be allocated (per Wkst. B,	673, 031	164	834	548		204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	7. 303012	0. 001190	0.009050	0. 035364	0. 000000	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

		LUTHERAN MUSCULUS		L 15 01/0 5		Wardington CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provider CCN		Period: From 01/01/2017	Worksheet B-1	
					o 12/31/2017		
	Cook Cooker Decoriestics	MUDCLNC	CENTRAL	DUADMACY	MEDICAL	5/31/2018 12:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINISTRATION	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRSING	(COSTED	REQUIS.)	(GROSS CHAR	(TIME SIENT)	
		HRS)	REQUIS.)		GES)		
		13.00	14. 00	15.00	16.00	17. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9.00
10. 00	01000 DI ETARY						10.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION	7, 298, 321					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	19, 514, 105				14. 00
15.00	01500 PHARMACY	0	3, 732	1, 261, 863	3		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(477, 433, 059		16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	(0	0	1
18. 00	01850 OTHER GENERAL SERVICES	0	0	(0	0	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	0	
20.00	02000 NURSI NG SCHOOL	0	0	(0	0	
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	(0	0	
22. 00 23. 00	O2200 L&R SERVICES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM	0	0	(0	
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U	UU) 0	U	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 004, 869	253, 051	(10, 218, 076	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	2,001,007	200, 001	(o o	
32.00	03200 CORONARY CARE UNIT	0	O	(0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	О	(0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	(0	0	
41. 00	04100 SUBPROVI DER - I RF	0	0	(0	0	
43. 00	04300 NURSERY	0	0	(0	0	
44.00	04400 SKILLED NURSING FACILITY	0	0	(0	0	
45. 00	04500 NURSING FACILITY	0	0	(0	0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	U U	υ	() 0	0	46.00
50. 00	05000 OPERATI NG ROOM	5, 139, 730	3, 295, 889	(186, 190, 725	0	50.00
51. 00	05100 RECOVERY ROOM	0, 107, 700	319, 305	(
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	Ö	
53.00	05300 ANESTHESI OLOGY	0	O	Ć	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	150, 031	3, 515	(8, 992, 750	0	54.00
54. 01	03630 ULTRA SOUND	0	0	(121, 297	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	
56. 00	05600 RADI OI SOTOPE	0	0	(0	1
	05700 CT SCAN	0	0	(7, 300	0	
58.00	05800 MRI	0	0	(81, 687	0	
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	3, 691	94, 054	(0 4 07E 00E	0	
60. 00	06001 BLOOD LABORATORY	3,091	94, 034	(4, 875, 805	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	١	٩	(1	l O	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o	(0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	ol	ő	(o o	Ö	
64. 00	06400 I NTRAVENOUS THERAPY		o	Ć	0	0	
65.00	06500 RESPI RATORY THERAPY	0	o	(471, 331	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	105, 858	(15, 359, 363	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	(421, 646		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	002 442	(0 22 720 202	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		983, 442 14, 455, 096	(23, 729, 383 146, 080, 433	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		14, 455, 070	1, 261, 863			
74.00	07400 RENAL DIALYSIS		0	1, 201, 00) 52,037,193	0	
75. 00	07500 ASC (NON-DISTINCT PART)		ol	(ol o	Ö	
	OUTPATIENT SERVICE COST CENTERS		<u> </u>				1
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	О	(0	0	89. 00
90.00	09000 CLI NI C	0	0	(0	0	
91. 00	09100 EMERGENCY	0	0	(0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
04.00			-1		\	1	1 04 00
94.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0	(

In Lieu of Form CMS-2552-10 Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (COSTED RECORDS & SUPPLY REQUIS.) LI BRARY (TIME SPENT) (DIRECT NRSING (GROSS CHAR (COSTED REQUIS.) HRS) GES) 15.00 17.00 13.00 14.00 16.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 0 0 98. 00 09850 OTHER REIMBURSABLE COSTS 0 0 98.00 0 99.00 09900 CMHC 0 0 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 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 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 0 106, 00 107.00 10700 LIVER ACQUISITION 0 0 107, 00 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION O 0 110 00 111.00 11100 I SLET ACQUISITION 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 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 7, 298, 321 19, 513, 942 1, 261, 863 477, 433, 059 0 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 163 0 193.00 193. 00 19300 NONPALD WORKERS 0 C 194. 00 07950 MARKETI NG 0 194.00 0 C 0 0 194. 01 07951 SENI OR CIRCLE 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, 1,099,745 1, 976, 783 629, 492 946, 510 0 202. 00 0. 000000 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 150685 0.101300 0.498859 0.001982 Cost to be allocated (per Wkst. B, 0 204. 00 204.00 1,801 223, 397 1,073 1,550

0.000247

0.011448

0.000850

0.000003

0.000000 205.00

206. 00

207. 00

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205.00

206.00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168

		OTHER GENERAL			i NTERNS &	5/31/2018 12:	
		SERVI CE					
	Cost Center Description	S (TIME SPENT)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		(TIME SIENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TI ME)	(ASSI GNED	(ASSI GNED	
		18. 00	19. 00	20.00	TI ME) 21. 00	TI ME) 22. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00	01850 OTHER GENERAL SERVICES	0					18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1			19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		C	0		20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0				0	22.00
	02300 PARAMED ED PRGM	0					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0			_	0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0			-	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	o	o	-	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	-	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		-	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	0			-	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	o		_	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	_	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS] 0	0) <u> </u>	0	0	46. 00
50. 00	05000 OPERATING ROOM	0	0		ol	0	50. 00
51. 00	05100 RECOVERY ROOM	0	O	1		0	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	0		-	0	53. 00 54. 00
54. 01	03630 ULTRA SOUND	0			Ó	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0) c	o	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
	05700 CT SCAN 05800 MRI	0			0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		-	0	59. 00
60.00	06000 LABORATORY	0	0	0	o	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	61. 00 62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		Ö	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0			0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0			ı	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	O	0	O	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) C		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	O	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0) C	0	0	75. 00
88 NN	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC) C	ol	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			ol ol	0	89. 00
90.00	09000 CLI NI C	0	0) C	o	0	90. 00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	O) C	이	0	91. 00 92. 00
7Z. UU	107200 ODSERVATION BEDS (NON-DISTINCT PART	I	I	I	ı I		72.00

| Period: | Worksheet B-1 | | From 01/01/2017 | | Date/Time Prepared: | 5/31/2018 | 12: 17 pm | |

						5/31/2018 12:	17 pm
		OTHER GENERAL			INTERNS &	RESI DENTS	
		SERVI CE					
	Cost Center Description	S	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	
	'	(TIME SPENT)	ANESTHETI STS		Y & FRINGES	PRGM COSTS	
		((ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
			II WL)	''''L'	TIME)	TIME)	
		18. 00	19. 00	20.00	21. 00	22. 00	
OTUED	DELMBURGARI E COCT CENTERC	10.00	17.00	20.00	21.00	22.00	
	REIMBURSABLE COST CENTERS						0.4.00
	HOME PROGRAM DIALYSIS	0	0			0	94. 00
	AMBULANCE SERVICES	0	0		0	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
	OTHER REIMBURSABLE COSTS	l ol	0	0	0	0	98. 00
99. 00 09900		o	0	0	0	ol	99. 00
99. 10 09910	CORE	0	0	0	0	0	99. 10
	I &R SERVI CES-NOT APPRVD PRGM	0	0	Ö	0	-	100. 00
	HOME HEALTH AGENCY	0	0	_	_		100.00
		l U		1 0	U	U	101.00
	AL PURPOSE COST CENTERS						405 00
	KIDNEY ACQUISITION	0	0				105. 00
	HEART ACQUISITION	0	0	•	0		106. 00
	LIVER ACQUISITION	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	ol	0	0	0	0	110. 00
	ISLET ACQUISITION	0	0	0	0		111. 00
	INTEREST EXPENSE		· ·				113. 00
	UTILIZATION REVIEW-SNF						114. 00
			0		0		115. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	U	_			
116. 00 11600		0		0			116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190. 00
191. 00 19100	RESEARCH	0	0	0	0		191. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193. 00 19300	NONPALD WORKERS	o	0	0	0	0	193. 00
194. 00 07950		0	0	0	0	0	194. 00
	SENI OR CI RCLE	0	0		0		194. 01
	Cross Foot Adjustments	Ĭ	0	Ĭ			200. 00
	Negative Cost Centers						200.00
	9						
	Cost to be allocated (per Wkst. B,	0	0	0	0	0	202. 00
	Part I)						
	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	
	Cost to be allocated (per Wkst. B,	0	0	0	0	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0.000000	0.000000	0.000000	0.000000	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated			0			206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,	1		0.000000			207. 00
	Parts III and IV)						
1 1		'		1	1	'	

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17 00 18.00 01850 OTHER GENERAL SERVICES 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0000000 31.00 32 00 03200 CORONARY CARE UNIT 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 40.00 41 00 41 00 04300 NURSERY 43.00 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 0 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 000000000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 03630 ULTRA SOUND 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 57.00 05800 MRI 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 00000000000 63.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 07400 RENAL DIALYSIS 74.00 74.00 75 00 07500 ASC (NON-DISTINCT PART) 75 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 90.00 90 00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94 00 0 95.00 09500 AMBULANCE SERVICES 0 95.00

0

96.00

09600 DURABLE MEDICAL EQUIP-RENTED

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	ieu of Form CMS-2552-10	
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0168	Peri od:	Worksheet B-1	

COST AL	LOCATION - STATISTICAL BASIS		Provider CCN: 15-0168	Period: From 01/01/2017	Worksheet B-1	l
				To 12/31/2017		
	Cook Cook on Brooming time	PARAMED ED		<u> </u>	5/31/2018 12:	1 / pm
	Cost Center Description	PRGM PRGM				
		(ASSI GNED				
		TIME)				
		23. 00				
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0				97. 00
	09850 OTHER REIMBURSABLE COSTS	o				98. 00
	09900 CMHC	o				99.00
	09910 CORF	o				99. 10
	10000 L&R SERVICES-NOT APPRVD PRGM	o				100.00
1	10100 HOME HEALTH AGENCY	o				101.00
-	SPECIAL PURPOSE COST CENTERS	-1				
105.00	10500 KIDNEY ACQUISITION	0				105. 00
106.00	10600 HEART ACQUISITION	o				106. 00
	10700 LIVER ACQUISITION	o				107. 00
	10800 LUNG ACQUISITION	o				108.00
	10900 PANCREAS ACQUISITION	o				109.00
	11000 INTESTINAL ACQUISITION	o				110.00
	11100 SLET ACQUISITION	o				111.00
	11300 INTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114.00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	o				115. 00
116.00	11600 HOSPI CE	o				116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0				118.00
1	NONREI MBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190. 00
191.00	19100 RESEARCH	0				191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0				192. 00
193.00	19300 NONPALD WORKERS	0				193. 00
194.000	07950 MARKETI NG	0				194. 00
194. 01 (07951 SENIOR CIRCLE	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,	0				202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000				203. 00
204. 00	Cost to be allocated (per Wkst. B,	0				204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000				205. 00
	[1]					
206. 00	NAHE adjustment amount to be allocated	0				206. 00
007.5	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000				207. 00
	Parts III and IV)					

	Financial Systems LL ATION OF RATIO OF COSTS TO CHARGES	JTHERAN MUSCULO	Provider C	CN: 15-0168 P	eri od:	u of Form CMS-2 Worksheet C	2552-10
				T	rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre 5/31/2018 12:	pared: 17 pm
			Titl€	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	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 440, 746	I	5, 440, 746	0	5, 440, 746	30.00
31. 00	03100 INTENSIVE CARE UNIT	0		0	o	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	33. 00 34. 00
40.00	04000 SUBPROVI DER - I PF	0		Ö	0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0		0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY				0	0	43. 00 44. 00
45.00	04500 NURSING FACILITY	0		0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		0	0	0	46. 00
50. 00	05000 OPERATING ROOM	17, 114, 518		17, 114, 518	0	17, 114, 518	50. 00
51.00	05100 RECOVERY ROOM	810, 575		810, 575	0	810, 575	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0		0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	724, 733		724, 733	0	724, 733	1
54. 01	03630 ULTRA SOUND	5, 096		5, 096	0	5, 096	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0		0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	4, 581	l .	4, 581	0	4, 581	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	5, 923		5, 923	0	5, 923 0	58. 00 59. 00
60.00	06000 LABORATORY	533, 190		533, 190	0	533, 190	1
60. 01	06001 BLOOD LABORATORY	0		0	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		Ö	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	10 440		10 440	0	10 440	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	18, 648 4, 623, 956		18, 648 4, 623, 956	0	18, 648 4, 623, 956	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	0	0	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	25, 542		0 25, 542	0	0 25, 542	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	926, 069 19, 112, 296		926, 069 19, 112, 296	0	926, 069 19, 112, 296	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 270, 727		2, 270, 727	0	2, 270, 727	73. 00
74.00	07400 RENAL DI ALYSI S	0		0	0	0	
75. 00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0		0	0	0	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		0	0	0	89. 00 90. 00
91. 00	09100 EMERGENCY	0		0	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	281, 151		281, 151		281, 151	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES	0		0	0	0	95. 00
96. 00 97. 00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	
98. 00	09850 OTHER REIMBURSABLE COSTS	0		ő	0	0	98. 00
99. 00 99. 10	09900 CMHC	0		0		0	
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM					0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0		0			101. 00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON	T 0		Ιο		0	105. 00
	10600 HEART ACQUISITION	0		Ö			106. 00
	10700 LIVER ACQUISITION	0		0			107. 00 108. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION						108.00
110.00	11000 INTESTINAL ACQUISITION			0		0	110. 00
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE	0		0		0	111. 00 113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0			115.00
200.00	11600 H0SPICE Subtotal (see instructions)	51, 897, 751	C	51, 897, 751	0	51, 897, 751	116. 00 200. 00
	1 1						

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	?	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0168			Period: From 01/01/2017	Worksheet C Part I	
			-	Го 12/31/2017	Date/Time Pre 5/31/2018 12:	pared: 17 pm_
		Title	: XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26) 1. 00	2.00	3.00	4.00	5. 00	
201.00 Less Observation Beds	281, 151		281, 15		281, 151	201. 00
202.00 Total (see instructions)	51, 616, 600	0	51, 616, 600	ol ol	51, 616, 600	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/31/2018 12:17 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0168

						0 12/31/201/	5/31/2018 12:	
					XVIII	Hospi tal	PPS	
		Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
	LNDAT	LENT DOUTING CEDIUSE COCT CENTEDS	6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	9, 655, 778		9, 655, 778			30. 00
31. 00		INTENSIVE CARE UNIT	0		0			31.00
32.00		CORONARY CARE UNIT	o		0			32.00
33. 00		BURN INTENSIVE CARE UNIT	0		0			33. 00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0		0			34. 00 40. 00
41. 00		SUBPROVIDER - IPF			0			41. 00
43. 00		NURSERY	o		ő			43. 00
44.00	1	SKILLED NURSING FACILITY	o		0			44. 00
45. 00		NURSING FACILITY	0		0			45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	l O		0			46. 00
50.00		OPERATI NG ROOM	73, 040, 055	113, 150, 670	186, 190, 725	0. 091919	0. 000000	50.00
51. 00	1	RECOVERY ROOM	11, 502, 149	17, 343, 919	28, 846, 068		0. 000000	
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 058, 021	7, 934, 729	8, 992, 750	0. 000000 0. 080591	0. 000000 0. 000000	
54. 01		ULTRA SOUND	96, 149	25, 148		0. 042013	0. 000000	
55. 00		RADI OLOGY-THERAPEUTI C	o	0	0		0. 000000	
56. 00		RADI OI SOTOPE	0	0	0		0. 000000	
57. 00 58. 00	05700	CT SCAN	7, 300 81, 687	0	7, 300 81, 687	0. 627534 0. 072508	0. 000000 0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	01,007	0	01,007	0.000000	0. 000000	
60.00		LABORATORY	3, 767, 922	1, 107, 883	4, 875, 805		0. 000000	1
60. 01		BLOOD LABORATORY	o	0	0	0. 000000	0. 000000	
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	1
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELL BLOOD STORING, PROCESSING & TRANS.	٥	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
64. 00		I NTRAVENOUS THERAPY	l o	0	Ö	0. 000000	0. 000000	
65. 00	06500	RESPI RATORY THERAPY	366, 784	104, 547	471, 331	0. 039565	0. 000000	
66.00		PHYSI CAL THERAPY	1, 564, 099	13, 795, 264	15, 359, 363		0.000000	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	1
69. 00		ELECTROCARDI OLOGY	144, 157	277, 489	421, 646		0. 000000	
70. 00	07000	ELECTROENCEPHALOGRAPHY	o	0	0	0. 000000	0. 000000	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	12, 304, 103	11, 425, 280			0.000000	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	104, 094, 656 21, 723, 226	41, 985, 777 30, 313, 969			0. 000000 0. 000000	
74. 00		RENAL DIALYSIS	0	0 0			0. 000000	
75.00		ASC (NON-DISTINCT PART)	O	0	0	0. 000000	0. 000000	75. 00
00.00		TIENT SERVICE COST CENTERS		0				00.00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER		0				88. 00 89. 00
90.00		CLINIC	Ö	0			0. 000000	
		EMERGENCY	o	0			0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	12, 635	549, 663	562, 298	0. 500004	0. 000000	92.00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	ol	0	0	0. 000000	0. 000000	94. 00
95. 00		AMBULANCE SERVI CES	o	Ö		0. 000000	0. 000000	1
96.00		DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	
97. 00	1	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	1
98. 00 99. 00	09900	OTHER REIMBURSABLE COSTS		0	0	0. 000000	0. 000000	98. 00 99. 00
	09910		o	0	Ö			99. 10
	1	I&R SERVICES-NOT APPRVD PRGM	o	0				100. 00
101.00		HOME HEALTH AGENCY	0	0	0			101. 00
105 00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	ol	0	0			105. 00
		HEART ACQUISITION	o	0			•	106. 00
		LIVER ACQUISITION	0	0	0			107. 00
	1	LUNG ACQUISITION	0	0	0			108. 00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION		0	0			109. 00 110. 00
		ISLET ACQUISITION		0	0			111.00
113.00	11300	INTEREST EXPENSE			_			113. 00
		UTILIZATION REVIEW-SNF	_	_	_			114.00
		AMBULATORY SURGICAL CENTER (D. P.) HOSPICE		0	0			115. 00 116. 00
200.00		Subtotal (see instructions)	239, 418, 721	238, 014, 338	477, 433, 059			200. 00
201.00		Less Observation Beds			<u> </u>		<u> </u>	201. 00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
				From 01/01/2017 To 12/31/2017	Part I	narod.
				10 12/31/2017	Date/Time Pre 5/31/2018 12:	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	239, 418, 721	238, 014, 338	477, 433, 05	9		202. 00

MARTI ENT REPUTINES SERVICE OST CENTERS 11.0 9 1.0 0 1					5/31/2018 12: 17 pm
NAMATIEST SQUITHE SERVICE COST CENTERS 10.00	Cost Conton Dosorintion	DDC Inpationt	Title XVIII	Hospi tal	PPS
The Note of Transport of Service Cost Centres 10.00 10.0	cost center bescription				
30.00 30.0					
31.00 03100 INTERSIVE CAME UNIT 32.00 03200 03000 03000 03100	INPATIENT ROUTINE SERVICE COST CENTERS				
32.00 30.000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.000000 50.000000 50.000000 50.000000 50.000000 50.0000000 50.0000000 50.0000000 50.00000000 50.00000000 50.000000000 50.0000000000					•
33.00 30.0	· · · · · · · · · · · · · · · · · · ·				
34.00					
40.00 04000 DIRECTOR 40.00 4					
41.00 04.00 SUBRROVIDER - 1 IRF 43.00 44.00					•
44.00 0460					•
45.00 01-500 01					43.00
46.00					
ARCILLARY SERVICE COST CENTERS 50.00 50500 (DEPARTING ROOM 0.091019 51.00 55.00	l +				
50.00 50.0					46.00
51.00 51.00 ECCUPERY ROOM & LABOR ROOM 0.020100 52.0		0 091919			50.00
52.00 05200 DELI VERY ROOM & LABOR ROW 0.000000 53.00 55.0		1			
54. 00 0.400 RAD 0.007 - DI ARROSTIC 0.000001 55. 00 56. 00 15. 00 0.00001 55. 00 0.00001 55. 00 0.0000000000 55. 00 0.0000000000		1			l l
54. 01 36.20 ULTRA SOUND 0. 042013 54. 01	53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
55.00	l +	1 1			
56. 00 5600 RADIO ISTORIPE 0.000000 55. 00 570. 00 5	l	1 1			
57.00 05700 CT SCAN 0.677534 57.00 58.00 59.00	1	1 1			ı
58.00 6800 MRI 0.072508 58.00 59.00 59.00 60.0	1	1 1			
59.00 05000 CARDIAC CATHETER IZATION 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					
60.00		1			
61.00 66100 PBP CLINICAL LAB SERVICES-PREM ONLY 0.000000 62.00 63.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66.		1			l l
62.00 6200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 66.2 00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66	60. 01 06001 BLOOD LABORATORY	1			60. 01
63.00 06.300 0.000 STORI NO, PROCESSI NO & TRANS. 0.000000 64.00 06.40 0.06400 NITRAYENDUS THERAPY 0.000000 65.00 06.500 RESPIRATORY THERAPY 0.039565 65.00 06.500 RESPIRATORY THERAPY 0.000000 67.00 06.70 0.067000 0.06700 0.06700 0.06700 0.06700 0	61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
64. 00 06.400 INTRAVENOUS THERAPY 0.000000 6.60 06.500 RESPIRATORY THERAPY 0.301051 6.60 06.500 RESPIRATORY THERAPY 0.301051 6.60 06.500 RESPIRATORY THERAPY 0.301051 6.60 06.500 RESPIRATORY THERAPY 0.000000 6.70 0.670 0.00000 6.70 0.680 0.6800 SPEECH PATHOLOGY 0.000000 6.60 0.00000 6.60 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.00000000	l i	1			· ·
65.00 06500 RESPIRATORY THERAPY 0.039565 66.00 66.00 660.00 PMSICAL THERAPY 0.301051 66.00 66.00 660.00 PMSICAL THERAPY 0.301051 66.00 660.00 660.00 PMSICAL THERAPY 0.000000 68.00 660.00 06900 SPEECH PATHOLOGY 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.000000 77.00 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	· ·	1			
66.00 06600 PhYSI CAL THERAPY 0.301051 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 680.00		1			
67.00 06700 06700 06700 06700 06700 06700 06800 0680 06800 071.00 0710		1			•
68. 00 06800 SPECCH PATHOLOGY 0.000000 6.		1			•
69 00 06900 064CTRECCARDIOLOGY 0.060577 0.000000 071.00 0710000 0710000 0710000 0710000 0710000 0710000 0710000 0710000 0710000 0710000 07100000 07100000 07100000 07100000 07100000 07100000 07100000 07100000 071000000 071000000 071000000 0710000000 07100000000 071000000000 07100000000 071000000000 0710000000000		1			
17. 00 07.00 MDIL CAL SUPPLIES CHARGED TO PATIENT 0. 039026 72. 00 72.00 72.00 72.00 72.00 72.00 72.00 MDIL DEV. CHARGED TO PATIENTS 0. 130834 72. 00 73.00 74		1			•
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0.130834 72.00 07300 0					
73. 00 07300 DRIGS CHARGED TO PATIENTS 0. 043637 73. 00 074. 00 74.00 74.00 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0. 0000000 74. 00 07500 ASC (NON-DISTINCT PART) 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 00000000		0. 039026			71.00
74. 00 07400 RENAL DI ALYSIS 0.000000 07500 ASC (NON-DISTINCT PART) 0.000000 09000 CLINIC 0.000000 99. 00 09000 CLINIC 0.000000 99. 00 09000 CLINIC 0.000000 99. 00 09000 09000 CLINIC 0.000000 99. 00 090000 09000 09000 09000 09000 09000 09000 09000 09000		1			
75.00 07500 ASC (NON-DISTINCT PART) 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
OUTPATIENT SERVICE COST CENTERS 88. 00 88. 00 08800 RURAL HEALTH CLINIC 89. 00 99. 00 09900 CEDERALLY QUALIFIED HEALTH CENTER 99. 00 90. 00 09000 CLINIC 0. 000000 99. 00 91. 00 09100 MERGENCY 0. 000000 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART 0. 500004 92. 00 94. 00 09400 HOME PROGRAM DI ALYSIS 0. 000000 95. 00 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 97. 00 09700 09700 09800 09800 09800 09800 09800 09800 09800 09800 09800 09800 09800 99. 00 09900 098		1			
88.00 089.00 10800 RIRAL HEALTH CLINIC 89.00 99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 9.00 99.00 09000 CLINIC 0.000000 99.00 91.00 09000 CLINIC 0.000000 99.00 92.00 09000 CLINIC 0.000000 99.10 00 09100 EMERGERCY 0.0000000 99.10 00 09100 EMERGERCY 0.0000000 99.10 00 09100 EMERGERCY 0.000000 99.10 00 09200 OSERVATION BEDS (NON-DISTINCT PART 0.500004 92.00 0THER REIMBURSABLE COST CENTERS 94.00 094.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 98.00 09950 OTHER REIMBURSABLE COSTS 0.000000 97.00 99.00 09900 CMIRC 99.00 99.00 09900 OMBE		0.000000			75.00
89.00 89.00 89.00 89.00 90.0					88. 00
91. 00 09100 BMERGENCY 0.000000 92. 00 09200 095ERVATION BEDS (NON-DISTINCT PART 0.500004 92. 00 09500 ABULANCE SERVICES 0.000000 95. 00 09500 ABULANCE SERVICES 0.000000 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97. 00 09900 CMRC 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09000 BASSENIA EXAMPLE ASSENIA EXAM	1				
92. 00 09200 00SERVATION BEDS (NON-DISTINCT PART 0.500004 92. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 95. 00 95. 00 09500 AMBULANCE SERVI CES 0.000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0.000000 97. 00 99. 00 09900 CMHC 99. 00 99. 10 09910 CORF 99. 10 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 101000 HEALTH AGENCY 99. 10 SPECIAL PURPOSE COST CENTERS 101. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 106. 00 10600 HEART ACQUI SI TI ON 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 INTERSTI EXPENSE 111. 00 111. 00 11100 ISLET ACQUI SITI ON 110. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTIL ZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 10000 Subtotal (see instructions) 200. 00 201. 00 Subtotal (see instructions) 200. 00 201. 00 Subtotal (see instructions) 200. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 20	90. 00 09000 CLI NI C	0. 000000			90.00
OTHER REIMBURSABLE COST CENTERS		0. 000000			•
94. 00 09400 HOME PROGRAM DIALYSIS 0.000000 95. 00 9500 AMBULANCE SERVICES 0.000000 97. 00 95. 00 9500 09600 DURABLE MEDICAL EQUIP-SOLD 0.000000 97. 00 9		0. 500004			92. 00
95. 00 09500 AMBULANCE SERVICES 0.000000 96. 00 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09800 OTHER REI MBURSABLE COSTS 0.000000 99. 00 09900 CMHC 99. 00 99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 09910 CORF 100. 00 10000 IAR SERVICES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 11000 INTESTI NAL ACQUI SI TI ON 109. 00 11100 INTESTI NAL ACQUI SI TI ON 111. 00 11100 ISLET ACQUI SI TI ON 111. 00 11100 ISLET ACQUI SI TI ON 111. 00 11100 INTERST EXPENSE 111. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11500 MBULATORY SURGI CAL CENTER (D. P.) 115. 00 1000 Subtotal (see instructions) Less Observation Beds 201. 00		0.000000			04.00
96. 00 99600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 97.00 97.00 98.00 98.00 98.00 98.00 98.00 99.00 99.00 99.00 99.00 09900 CMHC 99.00 99.00 99.00 99.00 18R SERVI CES-NOT APPRVD PRGM 100.00 100.00 100.00 18R SERVI CES-NOT APPRVD PRGM 100.00 101.00 HOME HEALTH AGENCY 101.00 1					
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0.000000 99. 00 09900 CMHC 99. 00 09910 CORF 99. 00 09910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 00910 CORF 99. 10 CORF 99. 10 00910 CORF 99. 10 CORF 99					
98. 00		1 1			
99. 10	l i	1			
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HMBE HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUISITION 106.00 107.00 10700 LI VER ACQUISITION 107.00 10700 LI VER ACQUISITION 108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 110.00 110.00 110.00 111.00 115.00 115.00 115.00 AMBULATORY SURGICAL CENTER (D. P.) 115.00 116.00 10901 CSUBLATORY SURGICAL CENTER (D. P.) 116.00 116.00 1000	99. 00 09900 CMHC				99. 00
101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 106.00 10700 LIVER ACQUI SI TI ON 107.00 10700 LIVER ACQUI SI TI ON 108.00 LUNG ACQUI SI TI ON 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 1000 INTESTI NAL ACQUI SI TI ON 110.00 111.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 ISLET ACQUI SI TI ON 111.00 113.00 INTERST EXPENSE 113.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115.00 116.00 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00					99. 10
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 10600 HEART ACQUI SI TI ON 106. 00 10700 LI VER ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 110. 00 INTESTI NAL ACQUI SI TI ON 110. 00 111. 00 INTESTI NAL ACQUI SI TI ON 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 116. 00 11600 HOSPI CE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00					•
105. 00 105. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 109. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 113. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 0					101.00
106. 00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION 107. 00 108.00 10800 LUNG ACQUISITION 108.00 109.00 10900 PANCREAS ACQUISITION 109.00 110. 00 110.00 110.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 111.00 ISLET ACQUISITION 111.00 INTESTINAL ACQUISITION 113.00 11300 INTEREST EXPENSE 1114.00 11400 UTILIZATION REVIEW-SNF 115.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 116.00 116.00 11600 CSubtotal (see instructions) 116.00 Less Observation Beds 201.00					105.00
107. 00 10700					
108. 00 10800 LUNG ACQUISITION 109. 00 109. 00 109. 00 109. 00 109. 00 10. 00 1					
109. 00 10900 PANCREAS ACQUISITION 109. 00 110. 00 11000 INTESTINAL ACQUISITION 110. 00 1110. 01 11100 ISLET ACQUISITION 111. 00 1113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00 11600 HOSPICE 116. 00 1000 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00					
110. 00					•
113.00 11300 1NTEREST EXPENSE					•
114.00					
115. 00					•
116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					•
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					•
201.00 Less Observation Beds 201.00					•
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	(222 :	1 I			1202.00

	•	LUTHERAN MUSCULUS				U OT FORM CMS-2	2552-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
					To 12/31/2017	Date/Time Pre	pared:
						5/31/2018 12:	17 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	I ENT ROUTINE SERVICE COST CENTERS	1			.1		
	ADULTS & PEDIATRICS	5, 440, 746		5, 440, 74		5, 440, 746	
1	INTENSIVE CARE UNIT	0			0 0	0	
•	CORONARY CARE UNIT	0		1	0 0	0	
	BURN INTENSIVE CARE UNIT	0			0 0	0	
	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0			0 0	0	0 00
	SUBPROVIDER - IPF	0				0	41. 00
	NURSERY	0				0	43.00
•	SKILLED NURSING FACILITY	0			0 0	0	ı
	NURSING FACILITY				0 0	0	i
	OTHER LONG TERM CARE	0			0 0	0	46. 00
	LARY SERVICE COST CENTERS	<u> </u>			0	0	1 40.00
	OPERATING ROOM	17, 114, 518		17, 114, 51	8 0	17, 114, 518	50.00
	RECOVERY ROOM	810, 575		810, 57		810, 575	
	DELIVERY ROOM & LABOR ROOM	0			0 0	0	•
	ANESTHESI OLOGY	0			0 0	0	
	RADI OLOGY-DI AGNOSTI C	724, 733		724, 73	3 0	724, 733	54.00
54. 01 03630	ULTRA SOUND	5, 096		5, 09	6 0	5, 096	54. 01
55. 00 05500	RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
56. 00 05600	RADI OI SOTOPE	0			0 0	0	56. 00
	CT SCAN	4, 581		4, 58		4, 581	57. 00
58. 00 05800		5, 923		5, 92	3 0	5, 923	•
	CARDIAC CATHETERIZATION	0			0	0	
•	LABORATORY	533, 190		533, 19	0	533, 190	•
•	BLOOD LABORATORY	0			0	0	60. 01
1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	
	BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63. 00 64. 00
•	RESPIRATORY THERAPY	18, 648	_	18, 64	-	18, 648	1
•	PHYSICAL THERAPY	4, 623, 956		4, 623, 95		4, 623, 956	1
	OCCUPATIONAL THERAPY	4,023,730		4, 023, 93	0	4, 023, 430	1
	SPEECH PATHOLOGY	0				Ö	ı
	ELECTROCARDI OLOGY	25. 542	_	25, 54	2 0	25, 542	ł
•	ELECTROENCEPHALOGRAPHY	0			0 0	0	ı
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	926, 069		926, 06	9 0	926, 069	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	19, 112, 296		19, 112, 29		19, 112, 296	72. 00
	DRUGS CHARGED TO PATIENTS	2, 270, 727		2, 270, 72	.7	2, 270, 727	73. 00
	RENAL DIALYSIS	0			0	0	
	ASC (NON-DISTINCT PART)	0			0 0	0	75. 00
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0			0 0	0	88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
	CLINIC	0				0	
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	281, 151		281, 15	0	0 281, 151	
	R REIMBURSABLE COST CENTERS	201, 131		201, 13	1	201, 131	72.00
	HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
	AMBULANCE SERVICES	0		1	0 0	Ö	
	DURABLE MEDICAL EQUIP-RENTED	0			o o	0	1
	DURABLE MEDICAL EQUIP-SOLD	o			o o	0	1
	OTHER REIMBURSABLE COSTS	O			0 0	0	1
99. 00 09900	CMHC	O			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
	HOME HEALTH AGENCY	0			0	0	101. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0			0		105. 00
	HEART ACQUISITION	0			0		106.00
	LIVER ACQUISITION	0			0		107.00
	LUNG ACQUISITION PANCREAS ACQUISITION	0					108. 00 109. 00
	INTESTINAL ACQUISITION				ŏ		1109.00
	ISLET ACQUISITION				o l		111.00
	INTEREST EXPENSE				<u> </u>		113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	o			0		115. 00
116. 00 11600	, , ,	0			0		116. 00
200.00	Subtotal (see instructions)	51, 897, 751	C	51, 897, 75	1 0	51, 897, 751	200. 00

Health Fin	ancial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	₹	In Lie	eu of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der Co	Provider CCN: 15-0168		Worksheet C	
					From 01/01/2017 To 12/31/2017	Part Date/Time Pre	pared:
						5/31/2018 12:	17 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
201.00	Less Observation Beds	281, 151		281, 15	1	281, 151	201. 00
202. 00	Total (see instructions)	51, 616, 600	0	51, 616, 60	0	51, 616, 600	202. 00
		·	•		"		

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0168

			T: +1		0 12/31/201/	5/31/2018 12:	
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	A NOATH ENT. DOUTLING OFFINA OF COOK OFFINEDO	6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	9, 655, 778		9, 655, 778			30.00
1	03100 INTENSIVE CARE UNIT	9,033,770		7, 033, 770			31.00
	03200 CORONARY CARE UNIT	o					32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		(33. 00
	03400 SURGICAL INTENSIVE CARE UNIT	0		C			34.00
	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0					40. 00 41. 00
1	04300 NURSERY	0					43.00
	04400 SKILLED NURSING FACILITY	o		d			44. 00
	04500 NURSING FACILITY	0		C			45. 00
	04600 OTHER LONG TERM CARE	0		C			46. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	73, 040, 055	113, 150, 670	186, 190, 725	0. 091919	0. 000000	50.00
1	05100 RECOVERY ROOM	11, 502, 149	17, 343, 919			0. 000000	51.00
1	05200 DELIVERY ROOM & LABOR ROOM	0	0)		0. 000000	52.00
	05300 ANESTHESI OLOGY	0	0) c	0. 000000	0. 000000	53. 00
1	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	1, 058, 021	7, 934, 729			0.000000	54.00
	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	96, 149 0	25, 148 0	121, 297	0. 042013 0. 000000	0. 000000 0. 000000	54. 01 55. 00
	05600 RADI OI SOTOPE	o	0		0. 000000	0. 000000	56.00
	05700 CT SCAN	7, 300	0	7, 300		0. 000000	57. 00
	05800 MRI	81, 687	0	81, 687		0. 000000	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	1 107 003	4 075 005		0.000000	59. 00 60. 00
	06000 LABORATORY 06001 BLOOD LABORATORY	3, 767, 922	1, 107, 883	4, 875, 805	0. 109354 0. 000000	0. 000000 0. 000000	60.00
1	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	o	0		0. 000000	0. 000000	61.00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) c	0. 000000	0. 000000	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0) c	0. 000000	0. 000000	63. 00
	06400 I NTRAVENOUS THERAPY	0	104 547	(471 221	0.000000	0.000000	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	366, 784 1, 564, 099	104, 547 13, 795, 264			0. 000000 0. 000000	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	0	13, 773, 204	13, 337, 303	0. 000000	0. 000000	67.00
1	06800 SPEECH PATHOLOGY	0	0) c	0. 000000	0. 000000	68. 00
	06900 ELECTROCARDI OLOGY	144, 157	277, 489	421, 646		0. 000000	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 12, 304, 103	0 11, 425, 280	23, 729, 383	0. 000000 0. 039026	0. 000000 0. 000000	70. 00 71. 00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	104, 094, 656	41, 985, 777			0. 000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	21, 723, 226	30, 313, 969			0. 000000	73. 00
	07400 RENAL DIALYSIS	0	0) c	0. 000000	0. 000000	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0) <u> </u>	0.000000	0. 000000	75. 00
	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	ol	0	ol c	0.000000	0. 000000	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	1		0. 000000	
	09000 CLI NI C	0	0) c		0. 000000	
	09100 EMERGENCY	0	0	0		0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	12, 635	549, 663	562, 298	0. 500004	0. 000000	92. 00
	09400 HOME PROGRAM DIALYSIS	O	0) C	0. 000000	0. 000000	94.00
	09500 AMBULANCE SERVICES	o	0			0. 000000	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0) c		0. 000000	96. 00
1	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0. 000000	0. 000000	97. 00
	09850 OTHER REIMBURSABLE COSTS	0	0		0. 000000	0. 000000	98.00
	09900 CMHC 09910 CORF	0	0				99. 00 99. 10
1	10000 I&R SERVICES-NOT APPRVD PRGM	o	0				100.00
1	10100 HOME HEALTH AGENCY	0	0	C			101. 00
	SPECIAL PURPOSE COST CENTERS				1		
1	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0 0	0	1			105. 00 106. 00
	10700 LI VER ACQUI SI TI ON	0	0				108.00
	10800 LUNG ACQUISITION	o	0				108. 00
109. 00	10900 PANCREAS ACQUISITION	0	0) c			109. 00
1	11000 I NTESTI NAL ACQUI SI TI ON	0	0) C			110.00
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE	0	0	rj C			111. 00 113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0	o c			115. 00
116. 00	11600 HOSPI CE	0	0) c			116. 00
200.00	Subtotal (see instructions)	239, 418, 721	238, 014, 338	477, 433, 059			200.00
201. 00	Less Observation Beds	<u> </u>		1	<u> </u>		201. 00

Health Financial Systems	LUTHERAN MUSCULOS	In Lie	u of Form CMS-	2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
				From 01/01/2017 To 12/31/2017	Part Date/Time Pre	epared:
					5/31/2018 12:	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	239, 418, 721	238, 014, 338	477, 433, 05	9		202. 00

Cost Center Description PPS Inpatient Ratio 11.00 Title XIX Hospita	al Cost
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	30.00
31.00 03100 INTENSIVE CARE UNIT	31.00
32. 00 03200 CORONARY CARE UNI T	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	40. 00 41. 00
43. 00 04300 NURSERY	43.00
44.00 04400 SKILLED NURSING FACILITY	44. 00
45.00 04500 NURSING FACILITY	45. 00
46.00 O4600 OTHER LONG TERM CARE	46. 00
ANCI LLARY SERVI CE COST CENTERS	50.00
50. 00 05000 OPERATI NG ROOM	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	52.00
53. 00 05300 ANESTHESI OLOGY 0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000	54.00
54. 01 03630 ULTRA SOUND 0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	55. 00
56. 00 05600 RADI 0I SOTOPE	56. 00 57. 00
58. 00 05800 MRI	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	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	64. 00
65. 00 06500 RESPI RATORY THERAPY	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	68. 00
69. 00 06900 ELECTROCARDI OLOGY	69. 00 70. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S 0. 000000	74. 00
75. 00 07500 ASC (NON-DI STINCT PART) 0. 000000	75. 00
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINI C 0.000000	88. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER	89.00
90. 00 09000 CLI NI C 0. 000000	90.00
91. 00 09100 EMERGENCY 0. 000000	91.00
92. 00	92. 00
OTHER REIMBURSABLE COST CENTERS	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0. 000000	94. 00 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000	97. 00
98. 00 09850 OTHER REI MBURSABLE COSTS 0. 000000	98. 00
99. 00 09900 CMHC	99. 00
99. 10 09910 CORF	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	105. 00
106.00 10600 HEART ACQUISITION	106. 00
107.00 LIVER ACQUISITION	107. 00
108. 00 10800 LUNG ACQUI SI TI ON	108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 I NTESTINAL ACQUISITION	109. 00 110. 00
111. 00 11000 TNTESTINAL ACQUISITION	111. 00
113. 00 11300 NTEREST EXPENSE	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	115. 00
116. 00 11600 HOSPI CE	116. 00
200.00 Subtotal (see instructions)	200. 00 201. 00
201.00 Less Observation Beds 202.00 Total (see instructions)	201.00
	1232. 00

		SKELETAL CENTER			u of Form CMS-	2332 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	20818	Provi der C	CN: 15-0168	Peri od: From 01/01/2017	Worksheet D Part I	
				To 12/31/2017	Date/Time Pre	
		T: 11	VA / I I I		5/31/2018 12:	17 pm
C+ C+ D	0: +-1		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Rel ated Cost	Swing Bed	Reduced	Total Patient		
	(from Wkst. B,	Adjustment	Capi tal Rel ated Cos	Days	3 / col . 4)	
	Part II, col.		(col. 1 - col			
	26)		2)	. ,		
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	547, 162	C	547, 10	5, 941	92, 10	30.00
31. 00 INTENSIVE CARE UNIT	0		,	0 0	0.00	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	
40. 00 SUBPROVI DER - I PF	0	C		0 0	0.00	
41. 00 SUBPROVI DER - I RF	0	C		0 0	0.00	41.00
43. 00 NURSERY	0			0 0	0.00	43. 00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	547, 162		547, 10	5, 941		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00				
30.00 ADULTS & PEDIATRICS	1, 863	171, 582	,			30.00
31. 00 INTENSIVE CARE UNIT	1, 603					31.00
32. 00 CORONARY CARE UNIT	0					32.00
33. 00 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 SURGI CAL INTENSI VE CARE UNI T	0					34.00
40. 00 SUBPROVI DER - I PF	0					40.00
41. 00 SUBPROVI DER – I RF	0					41. 00
43. 00 NURSERY	0					43.00
44.00 SKILLED NURSING FACILITY	0					44. 00
	0	Č				45. 00
45. 00 NURSING FACILITY	()	Ι .				

Health Financial Systems	LUTHERAN MUSCULOSKE	LETA	L CEN	TER		In Lie	u of Form CMS-2552-10
		_					

Heal th	Financial Systems LL	JTHERAN MUSCULO	SKELET	AL CENTER	₹	In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Pr	ovider C	CN: 15-0168	Peri od:	Worksheet D	
						From 01/01/2017	Part II	
						To 12/31/2017	Date/Time Pre	pared:
				Ti +l c	xVIII	Hospi tal	5/31/2018 12: PPS	17 pili
	Cost Center Description	Capi tal	Total		Ratio of Cos		Capital Costs	
	Cost Center Description	Related Cost				Program	(column 3 x	
		(from Wkst. B,			(col . 1 ÷ col		column 4)	
		Part II, col.	lait	8)	2)	. Charges	COT dillit 4)	
		26)		0)				
		1.00	2	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		-	00	0.00	11 00	0.00	
50.00	05000 OPERATING ROOM	1, 241, 963	186	5, 190, 725	0.00667	0 30, 896, 674	206, 081	50.00
51.00	05100 RECOVERY ROOM	334, 115	1	3, 846, 068	1		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1	0	0.00000		0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	76, 640	ا ا	3, 992, 750	1		7, 544	54.00
54. 01	03630 ULTRA SOUND	8	1	121, 297	1		0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0.00000		0	55. 00
56. 00	05600 RADI OI SOTOPE	0		0	0.00000		0	56. 00
57. 00	05700 CT SCAN	7	-	7, 300	1		0	57. 00
58. 00	05800 MRI	9	,	81, 687	1		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	Ó	J	0.,00,	0.00000		0	59. 00
60.00	06000 LABORATORY	1, 934	1	ı, 875, 805	1		1	60.00
60. 01	06001 BLOOD LABORATORY	1, ,51		1, 070, 000 N	0.00000		0,72	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			Ü	0.0000	.0	Ĭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	J	0	0. 00000	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1	0	0.00000		0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	1	0	0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	30	1	471, 331	1		_	65. 00
66. 00	06600 PHYSI CAL THERAPY	548, 627	1	5, 359, 363	1			
67. 00	06700 OCCUPATI ONAL THERAPY	0	ł	, 337, 303 N	0.00000		0 33, 230	67. 00
68. 00	06800 SPEECH PATHOLOGY		1	0	0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	41		421, 646			-	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1 0	1	421, 040	0.0000		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 606	1	3, 729, 383			-	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	194, 331		5, 727, 303 5, 080, 433				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 748		2, 037, 195			371	73. 00
74. 00	07400 RENAL DIALYSIS	3,740	1	., 037, 173 0	0.00000			74.00
	07500 ASC (NON-DISTINCT PART)		1	0			-	1
75.00	OUTPATIENT SERVICE COST CENTERS	0	′1		ų 0.0000t	0		75.00
88. 00	08800 RURAL HEALTH CLINIC	T 0	ı .	0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0	0.00000		-	89. 00
90. 00	09000 CLINIC	0		0	0.00000		1	90.00
91. 00	09100 EMERGENCY		()	0	0.00000		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	28, 275		562, 298			-	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	20,273	'1	302, 290	0.03020	12,000	033	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0	ı	0	0.00000	00 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			Ü	0.0000	.0	Ĭ	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	_		\cap	0. 00000	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD			0	0.00000		0	97. 00
98. 00	09850 OTHER REIMBURSABLE COSTS			0	0.00000		0	98. 00
200.00		2, 442, 334	467	ں 7, 777, 281		78, 497, 711		
200.00	1.5ta. (11165 55 th 5agh 177)	2, 112, 334	, .07	, . , , 201	1	10,177,711	317,704	1200.00

Health Financial Systems LU	JTHERAN MUSCULO	SKELETAL CENTER	?	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Peri od:	Worksheet D	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	pared:
					5/31/2018 12:	17 pm
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0			0	0	1
40. 00 04000 SUBPROVI DER - I PF	0	1			0	1
41. 00 04100 SUBPROVI DER - RF	0	1		0 0	0	
43. 00 04300 NURSERY		1		0	0	43.00
	0	0		0	U	1
44. 00 04400 SKILLED NURSING FACILITY	0	0		0		44. 00
45. 00 04500 NURSI NG FACI LI TY	0	0	1	U U		45. 00
200.00 Total (lines 30 through 199)	0	0	(0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	,	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 94°	1 0.00	1, 863	30.00
31.00 03100 INTENSIVE CARE UNIT		l 0		0.00	0	31.00
32. 00 03200 CORONARY CARE UNIT		0		0.00	•	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	1	0.00	0	
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				0.00	1	1
40. 00 04000 SUBPROVI DER - PF	0	0		0.00	l	
41. 00 04100 SUBPROVI DER - I RF				0.00	•	1
43. 00 04100 SUBPROVIDER - TRP	0			0.00	0	1
		1				
44. 00 04400 SKILLED NURSING FACILITY		0		0.00	l	
45. 00 04500 NURSI NG FACI LI TY		0		0.00	l .	10.00
200.00 Total (lines 30 through 199)		0	5, 94	1	1, 863	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	1				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	1				34.00
40. 00 04000 SUBPROVI DER - PF	0	1				40. 00
	1					1
41. 00 04100 SUBPROVI DER - RF	0	l .				41.00
43. 00 04300 NURSERY	0					43. 00
44.00 O4400 SKILLED NURSING FACILITY	0					44. 00
45.00 O4500 NURSING FACILITY	0	l .				45. 00
200.00 Total (lines 30 through 199)	0					200. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet D | From 01/01/2017 Part IV | To 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm Provider CCN: 15-0168 THROUGH COSTS

								5/31/2018 12: 1	17 pm
				Ti tl e	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nur	sing School	Nursi na	School	Allied Health	Allied Health	
	5551 551161 25551 Pt. 511			st-Stepdown	lu. sg	0000.	Post-Stepdown	/ II / I od i iodi iii	
		Cost		djustments			Adjustments		
		1.00	AC	2A	2.0	ın	3A	3. 00	
	ANCILL ADV. CEDVI CE. COCT. CENTEDO	1.00		ZA	J 2. C	10	SA	3.00	
F0 00	ANCILLARY SERVICE COST CENTERS							0	F0 00
50. 00	05000 OPERATI NG ROOM	0	1	0	1	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	7	0	1	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	1	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0)	0	1	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	·	0	0	0	54.00
54.01	03630 ULTRA SOUND	0)	0	ı	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	ol	0	ı	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	ol .	0	ı	0	0	0	56.00
57. 00	05700 CT SCAN	0		0	l	0	0	0	57. 00
58. 00	05800 MRI			0	l	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		()	0]	0	0	0	59. 00
	1 1	0]	0		0	0	-	
60.00	06000 LABORATORY	0	1	0	1	0	U	0	60.00
60. 01	06001 BLOOD LABORATORY	0	'	Ü	1	Ü	U	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	1	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	1	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0)	0	1	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0)	0	1	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0		0	ı	0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0)	0	ı	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0	l	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY			0	l	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY			0	1	0	0	0	70. 00
			()	0		0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0]	0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1	0	1	0	0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	'	0	1	0	0	0	73. 00
	07400 RENAL DI ALYSI S	0	9	0	1	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	0		0	1	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0		0	0	0	89.00
90.00	09000 CLI NI C	0)	0	ı	0	0	0	90.00
91.00	09100 EMERGENCY	0	ol	0	ı	0	0	ol	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		_		0	-	0	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS		1					Ŭ	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	J	0	ı	0	0	0	94. 00
	09500 AMBULANCE SERVICES		Ί	U	1	U	۷	١	94. 00 95. 00
			J	^		^			
	09600 DURABLE MEDICAL EQUIP-RENTED]	0	1	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	'	0	1	0	0	0	97. 00
98. 00	09850 OTHER REI MBURSABLE COSTS	0	'	0	1	0	0	0	98. 00
200.00	Total (lines 50 through 199)	0)	0	1	0	0	0	200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12 Provider CCN: 15-0168 THROUGH COSTS

					10 12/31/2017	5/31/2018 12:	
			Ti tl e	xVIII	Hospi tal	PPS	.,
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C	1	186, 190, 725		
51. 00	05100 RECOVERY ROOM	0	C)	28, 846, 068		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0.000000	
53.00	05300 ANESTHESI OLOGY	0	C)	0	0.000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	8, 992, 750		
54. 01	03630 ULTRA SOUND	0	C)	121, 297		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	1	0	0.000000	
56. 00	05600 RADI OI SOTOPE	0	C	1	0	0. 000000	
57. 00	05700 CT SCAN	0	C		7, 300		
58. 00	05800 MRI	0	C	1	81, 687		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	1	0	0.000000	
60.00	06000 LABORATORY	0	C	1	4, 875, 805		60.00
60. 01	06001 BLOOD LABORATORY	0	C	1	0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0	0.000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	1	0	0.000000	63. 00
64.00	06400 NTRAVENOUS THERAPY	0	C	9	0	0.000000	64.00
65. 00	06500 RESPI RATORY THERAPY	0	C	1	471, 331		65. 00
66.00	06600 PHYSI CAL THERAPY	0	C	1	15, 359, 363		66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	C	1	0	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C	1) 404 (4)	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	C		421, 646		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 22 720 202	0.000000	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			23, 729, 383		
72.00	07200 DRUCS CHARGED TO PATIENTS	0			146, 080, 433		
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1	52, 037, 195		
74. 00 75. 00	07400 RENAL DIALYSIS	0	C			0.000000	
75.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	U		'	J 0	0. 000000	75. 00
88. 00	08800 RURAL HEALTH CLINIC	0	C	.I	0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	1		0.00000	
90.00	09000 CLINIC	0	C			0.00000	
91.00	09100 EMERGENCY	0	C			0.00000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	1	562, 298		
92.00	OTHER REIMBURSABLE COST CENTERS	U		'	302, 290	0.00000	92.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES			Ί	5	0.00000	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	_			0. 000000	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD					0.00000	97.00
98.00	09850 OTHER REIMBURSABLE COSTS					0.00000	
200.00	1		C		467, 777, 281		200.00
200.00	Trotal (Tries 50 tillough 177)	ı o		η ,	9 401, 111, 201	I	200.00

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0168	Peri od:	Worksheet D

From 01/01/2017 To 12/31/2017 Part IV Date/Time Prepared: THROUGH COSTS 5/31/2018 12:17 pm Title XVIII Hospi tal PPS Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. $(col. 6 \div col$ Costs (col. x col . 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 30, 896, 674 50.00 21, 143, 642 0 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 885, 223 54.00 1, 184, 408 0 54.01 03630 ULTRA SOUND 0.000000 0 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 0 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 Ω 0 05700 CT SCAN 57.00 0.000000 C 0 0 57.00 58.00 05800 MRI 0.000000 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 0 59.00 06000 LABORATORY 1, 439, 588 113, 662 0.000000 60 00 60 00 0 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 0 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 159, 229 16, 173 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 1, 546, 959 66.00 60, 441 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 108, 183 253, 147 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.000000 4, 308, 233 1, 652, 778 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 33, 982, 976 0 7, 523, 059 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 1, 847, 441 73.00 73.00 5, 158, 011 0 74.00 07400 RENAL DIALYSIS 0 0.000000 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88. 00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89 00 89 00 C 0 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 0 91.00 0.000000 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 101, 696 0.000000 92.00 12,635 0 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96.00 0 Λ 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COSTS 0.000000 0 98.00

78, 497, 711

0

33, 896, 447

0 200.00

200.00

Total (lines 50 through 199)

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0168	Peri od:	Worksheet D	
					From 01/01/2017	Part V	nanad.
					To 12/31/2017	Date/Time Pre 5/31/2018 12:	pareu: 17 nm
			Title	XVIII	Hospi tal	PPS	17 piii
			11 11 0	Charges	nospi tui	Costs	
	Cost Center Description	Cost to Charge	PS Reimbursed		Cost	PPS Services	
	oost conten beschiptren		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	,		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	<u>'</u>					
50.00	05000 OPERATI NG ROOM	0. 091919	21, 143, 642		0 0	1, 943, 502	50.00
51.00	05100 RECOVERY ROOM	0. 028100			0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 080591	1, 184, 408		0 0	95, 453	
54. 01	03630 ULTRA SOUND	0. 042013	0		0 0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00	05700 CT SCAN	0. 627534	0			0	57. 00
58. 00	05800 MRI	0. 072508	0		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 109354	113, 662		0 0	12, 429	60.00
60. 00	06001 BLOOD LABORATORY	0. 000000	113,002		0 0	12, 429	60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	Ü		0 0	Ü	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	1	0		0 0	0	64.00
	1	0. 000000	14 172		0 0	-	
65. 00	06500 RESPI RATORY THERAPY	0. 039565	16, 173		-1	640	65.00
66.00	06600 PHYSI CAL THERAPY	0. 301051	60, 441		0 0	18, 196	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	052 147		0 0	15 225	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 060577	253, 147		0 0	15, 335	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	4 (50 770		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 039026	1, 652, 778		0	64, 501	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 130834	7, 523, 059		0 0	984, 272	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 043637	1, 847, 441	32, 15		80, 617	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLI NI C	0. 000000	0		0	0	90. 00
91. 00	09100 EMERGENCY	0. 000000	0		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 500004	101, 696		0 0	50, 848	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COSTS	0. 000000	0		0 0	0	98. 00
200.00			33, 896, 447	32, 15	57 0	3, 265, 793	
201.00					0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		33, 896, 447	32, 15	57 0	3, 265, 793	202. 00

Peri od: Worksheet D From 01/01/2017 Part V To 12/31/2017 Date/Time Prepared: 5/31/2018 12:17 pm

					5/31/2018 12:	17 pm_
		Title	XVIII	Hospi tal	PPS	
	Cos	ts		<u> </u>		
Cost Center Description	Cost	Cost				
cost conten bescription	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
						FO 00
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	l ol	O				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o				54.00
54. 01 03630 ULTRA SOUND						54. 01
		0				
55. 00 05500 RADI OLOGY-THERAPEUTI C	l 0	0				55. 00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MRI	l ol	ol				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o				59.00
60. 00 06000 LABORATORY		o				60.00
						1
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	O				63. 00
64.00 06400 INTRAVENOUS THERAPY	0	o				64.00
65. 00 06500 RESPIRATORY THERAPY	ام	o				65. 00
66. 00 06600 PHYSI CAL THERAPY		0				66.00
		٩				1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ol				71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	ام				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 403	Ö				73. 00
	1	-1				1
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	o				89. 00
90. 00 09000 CLI NI C	0	o				90.00
	-					
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	0	٩				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o				96.00
						1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0				98. 00
200.00 Subtotal (see instructions)	1, 403	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1, 403	О				202. 00
202.00 Met ondriges (Trile 200 Trile 201)	1,403	٥Į				1202.00

APPORTI O	DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CO	CN: 15-0168	Peri od:	Worksheet D	
					From 01/01/2017	Part V	
					To 12/31/2017	Date/Time Pre 5/31/2018 12:	parea: 17 nm
-			Ti +I	e XIX	Hospi tal	Cost	17 pili
			11 (1	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge P	DS Paimhursad	Cost	Cost	PPS Servi ces	
	cost center bescription		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 11131.)	
		Part I, col. 9	11131.)	Subject To	Subject To		
		di t 1, coi. /		Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
10	NCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	5000 OPERATING ROOM	0. 091919	0		0 493, 325	0	50.00
	5100 RECOVERY ROOM	0. 028100	0		0 473, 323	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
			-		-1		
	5300 ANESTHESI OLOGY	0.000000	0		0 0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 080591	0		0 15, 923	0	54.00
	3630 ULTRA SOUND	0. 042013	0		0	0	54. 01
	5500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
	5600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
	5700 CT SCAN	0. 627534	0		0	0	57. 00
58. 00 0!	5800 MRI	0. 072508	0		0	0	58. 00
59. 00 0!	5900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00 0	6000 LABORATORY	0. 109354	0		0 1, 701	0	60.00
60. 01 0	6001 BLOOD LABORATORY	0. 000000	0		o o	0	60. 01
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	-		o o		61.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62. 00
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
	6400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
	6500 RESPIRATORY THERAPY	0. 039565	0		0 0	0	65. 00
	6600 PHYSI CAL THERAPY	1	-			O	66. 00
		0. 301051	0		0 71, 328	0	
	6700 OCCUPATIONAL THERAPY	0. 000000	0		0	0	67. 00
	6800 SPEECH PATHOLOGY	0.000000	0		0 0	0	68. 00
	6900 ELECTROCARDI OLOGY	0. 060577	0		0 1, 193	0	69. 00
	7000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 039026	0		0 27, 594	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 130834	0		0 102, 645	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 043637	0		0 262, 249	0	73. 00
74. 00 0	7400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
75. 00 0°	7500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
Ol	UTPATIENT SERVICE COST CENTERS						
88. 00 08	8800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00 08	8900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00 0	9000 CLI NI C	0. 000000	0		o o	0	90.00
	9100 EMERGENCY	0. 000000	0		0 0	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 500004	0		0 10, 762	0	92. 00
	THER REIMBURSABLE COST CENTERS	0. 00000 1			10,702		72.00
	9400 HOME PROGRAM DI ALYSI S	0. 000000			0		94. 00
	9500 AMBULANCE SERVICES	0. 000000	0		0		95. 00
	9600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
	9700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0			0	97.00
	9850 OTHER REIMBURSABLE COSTS	· •	0		0 0	0	98.00
1	•	0. 000000	0			O	
200.00	Subtotal (see instructions)		U		986, 720	0	200.00
201. 00	Less PBP Clinic Lab. Services-Program				0		201. 00
202.00	Only Charges (Line 200 Line 201)		0		007.700	0	202 00
202. 00	Net Charges (line 200 - line 201)	I I	0		0 986, 720	0	202. 00

Provider CCN: 15-0168

Cost Center Description					10 12/31/2017	5/31/2018 12:	
Cost Center Description			Ti tl	e XIX	Hospi tal		
Cost Center Description		Cos					
Rel Imbursed Servi cess Subject 1 To Ded & Colins Cese Inst.) Sept Colins Cese Inst.) Subject 1 To Ded & Colins Cese Inst.) Sept	Cost Center Description						
Services Subject to Ded. & Coins.							
Subject To Ded. & Coins Sobject To Ded. & Coins Ded. & Coin							
Dod. & Colns. Dod. & Colns							
See Inst. See							
ANCILLARY SERVICE COST CENTERS							
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 0FERTING ROOM 0 45,346 50.00 51.00	ANCLILARY SERVICE COST CENTERS	0.00	7.00				
51.00 OS100 RECOVERY ROOM SABOR ROOM O O O S2.00 S3.00 OS300 OS1300 OS1301 OS1300 O		0	45, 346				50.00
S2.00 05.200 05.200 05.200 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.300 05.401 05.300 05.401 05.300 05.401 05.300 05.401 05.300 05.401 05.300 05.401 05.300 05.500 05		0	0				1
53.00 05300 ANESTHESI OLOGY 0 0 0 53.00		0	0				
54. 00 05400 RADI OLOGY-DI AGNOSTIC 0 1, 283 54. 00		0					1
S4. 01 036.00 LITRA SOUND S4. 01		0	Ŭ				1
55. 00 05500 RADIO LOGY—THERAPPUTIC 0		0					1
56. 00 05.00 05.00 CADIO IL SOTOPE 0 0 0 0 0 0 0 0		0	ŭ				1
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		0					1
58.00 05800 INR		0	Ŭ				
59.00 05900 CARDIAC CATHETER ZATION 0 0 0 06000 LABORATORY 0 0 0 0 0 0 0 0 0		0	ŭ				1
60.00 06000 LABORATORY 0 0 186 60.00 60.01 61.00 66.00 61.00 66.00 61.00 66.00 61.00 61.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 62.00 63.00 63.00 63.00 60.00 63.00 63.00 60.00 63.00 63.00 60.00 63.00 60.00 63.00 60.00 60.00 60.00 63.00 60.00		0					
60. 01 06.001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0		0	· ·				1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0 0		0		•			
62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0		0	0				1
63. 00 06300 BLODD STORI NG, PROCESSING & TRANS. 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
64. 00 06400 NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
66. 00 06600 PHYSICAL THERAPY 0 21,473 66. 00 67. 00 67. 00 67. 00 68. 00 69. 00 69. 00 69. 00 72 69. 00 70.	64.00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
67. 00 06700 OCCUPATIONAL THERAPY O O O 0 68. 00 68. 00 06800 SPECCH PATHOLOGY O O O O 68. 00 06900 ELECTROCARDI OLOGY O O O 70. 00 07000 ELECTROCARDI OLOGY O O O 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT O 1,077 O 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS O 13,429 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS O 0 11,444 O 74. 00 07400 RENAL DI ALYSIS O O O 75. 00 07500 ASC (NON-DISTINCT PART) O O 75. 00 07500 ASC (NON-DISTINCT PART) O O 88. 00 08800 RURAL HEALTH CLINIC O O 90. 00 09000 CLINIC O O 91. 00 09000 CLINIC O O 92. 00 09000 CLINIC O 92. 00 09000 CLINIC O 94. 00 09000 DIRBABLE MEDI CAL EQUI P-RENTED O 95. 00 09500 DURABLE MEDI CAL EQUI P-RENTED O 96. 00 09800 O DURABLE MEDI CAL EQUI P-RENTED O 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED O 98. 00 09850 OHER RIMBURSABLE COSTS O 99. 00 O O 90. 00 O DURABLE MEDI CAL EQUI P-SOLD O 90. 00 O 90. 00 O DURABLE MEDI CAL EQUI P-SOLD O 90. 00 O 90. 00 O DURABLE MEDI CAL EQUI P-SOLD O 90. 00 O 90. 00 O O 90. 00 O	65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0	21, 473				66. 00
68. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
69. 00 06900 ELECTROCARDI OLOGY 0 72 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 72 71. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 72. 00 07000 ELECTROCARDI OLOGRAPHY 0 0 0 72. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 1,077 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 13, 429 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 11, 444 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 00 08800 RURAL HEALTH CLINI C 0 0 0 0 09. 00 09900 CLINI C 0 0 0 0 09. 00 09000 CLINI C 0 0 0 0 09. 00 09000 CLINI C 0 0 0 0 091. 00 09100 EMERGENCY 0 0 0 0 99. 00 092. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 0 5, 381 092. 00 094. 00 09500 AMBULANCE SERVI CES 0 0 99. 00 095. 00 09500 AMBULANCE SERVI CES 0 95. 00 096. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 097. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 098. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 0 0 0 098. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 0 0 0 0 00 099. 00	68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		0	72				69.00
71. 00		0					1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 13, 429 73. 00 733. 00 07300 DRUGS CHARGED TO PATIENTS 0 11, 444 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 74.00 DATE DIALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	1 077				
73. 00		0					1
74. 00		0					
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		, and a					1
SERVICE COST CENTERS SERVICE CENTERS		_					1
88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 92. 00 92. 00 93. 00 94. 00 95. 00 96. 00 97. 00 98. 00 99. 00			<u> </u>				73.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 90.00 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 91.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 5, 381) 92.00 000 000 000 0000 DIRER REI MBURSABLE COST CENTERS 0 0 95.00 95.00 96.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 98.00 09800 OTHER REI MBURSABLE COSTS 0 0 98.00 09800 OTHER REI MBURSABLE COSTS 0 0 98.00 000 000 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 99, 691 000 000 000 000 000 000 000 000 000 0		0	0				88 00
90. 00 09000 CLINIC 0 0 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 5, 381 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 5, 381 92. 00 07HER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0							1
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92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 5, 381 92. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 95. 00 95. 00 95. 00 95. 00 95. 00 96. 00 95. 00 96. 00 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97. 00 97. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 98. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0 0 99. 691 000 00		_					1
OTHER REI MBURSABLE COST CENTERS 94.00 94.00 94.00 95.00 95.00 95.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 98.00 9		_					1
94. 00 95. 00 95. 00 96. 00 96. 00 96. 00 97. 00 97. 00 98. 00 98. 00 99. 00		0	5, 381				J 92.00
95. 00 09500 AMBULANCE SERVICES 0 95. 00 96. 00 97. 00 97. 00 97. 00 97. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 99. 691 99. 69							04.00
96. 00 97. 00 97. 00 97. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 99.		1	0				1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 98. 00 98. 00 200. 00 Subtotal (see instructions) 0 0 99, 691 201. 00 0 0 0 0 0 0 0 0 0		0					1
98. 00 09850 OTHER REIMBURSABLE COSTS 0 0 0 0 0 0 0 0 0		0					1
200.00 Subtotal (see instructions)		0	0				1
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 201.00 Only Charges		0	0				1
Only Charges		0	99, 691				
		0					201. 00
202.00 Net Charges (line 200 - line 201) 0 99,691 202.00							
	202.00 Net Charges (line 200 - line 201)	0	99, 691	l			202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0168	From 01/01/2017	Worksheet D-1 Date/Time Pre 5/31/2018 12:	
	Title XVIII	Hospi tal	PPS	
Coot Conton Decemintion			•	

		Title XVIII	Hospi tal	5/31/2018 12: PPS	17 pm
	Cost Center Description	II the Aviii	1103pi tai	113	
	DATE AND DESCRIPTION OF THE PROPERTY OF THE PR			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-the Private room days (excluding swing-bed and observation bed day do not complete this line.	ped and newborn days)	ivate room days,	5, 941 5, 941 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roof reporting period		r 31 of the cost	5, 634 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swi ng-bed and	1, 863	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	3 .	,	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar year).	ear, enter O on this line	e)	0	13. 00
14. 00 15. 00		am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
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 reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through $December 5 \times Iine 17$)		ing period (line	5, 440, 746 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 5, 440, 746	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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			tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	5, 440, 746	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38 00	Adjusted general inpatient routine service cost per diem (see			915. 80	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	*		1, 706, 135	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
	Total Program general inpatient routine service cost (line 39	*		1, 706, 135	

Heal th	Financial Systems LL	THERAN MUSCULOSKE	ELETAL CENTER	R	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-0168	Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
			Title	e XVIII	Hospi tal	5/31/2018 12: PPS	17 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost In	patient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	О	0. (00 00	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units	l	0	0.0	0 00	0	43. 00
44. 00	CORONARY CARE UNIT	o o	0				44. 00
45. 00		0	0	1		0	45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.0	00 0	0	46. 00 47. 00
171.00	Cost Center Description	L		'			171 00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 8, 392, 984	48. 00
	Total Program inpatient costs (sum of lines			ons)		10, 099, 119	•
	PASS THROUGH COST ADJUSTMENTS					474 500	
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	n Wkst. D, sun	n of Parts I and	171, 582	50. 00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	317, 964	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				489, 546	52. 00
53. 00	Total Program inpatient operating cost exclu	,	ited, non-phy	sician anesth	netist, and	9, 609, 573	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
56. 00	Target amount (line 54 x line 55)	ing soot and taxa	ust smallet (1	ino E/ minuo	line E2)	0	56. 00 57. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	jet amount (i	The 56 III hus	11 ne 53)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period en	ndi ng 1996, ι	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report unda	ited by the m	narket hasket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line				the amount by	0.00	61. 00
	which operating costs (line 53) are less tha		(lines 54 x	60), or 1% of	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost renorti	na period (See	0	64. 00
0 00	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after December	31 of the c	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through D	locombor 21 c	of the cost re	porting ported	_	67. 00
07.00	(line 12 x line 19)	e costs through b	ecember 31 c	or the cost re	sporting perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	e 68)		О	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	· ·)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72. 00
73. 00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II, column		74. 00 75. 00
	26, line 45)		•		·		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces			· ·	1: 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st rimitation	ı (ııne /8 mir	ius iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (· ·					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					307	87. 00
88. 00	,		ine 2)			915. 80	
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				281, 151	89. 00

Health Financial Systems	UTHERAN MUSCULOS	SKELETAL CENTER	!	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	547, 162	5, 440, 746	0. 10056	7 281, 151	28, 275	90.00
91.00 Nursing School cost	0	5, 440, 746	0.00000	0 281, 151	0	91.00
92.00 Allied health cost	0	5, 440, 746	0.00000	0 281, 151	0	92.00
93 00 All other Medical Education	0	5 440 746	0.00000	0 281 151	0	93 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0168	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/31/2018 12:	pared:
	Title XIX	Hospi tal	Cost	
Cost Center Description			•	

No. Park 1 - All PROVIDER COMPONENTS 1.00			Title XIX	Hospi tal	5/31/2018 12: Cost	17 pm
Inpatient days (Including private room days and saing-bed days, excluding newborn) 5,947 1,00		Cost Center Description	THE MAN	neop. ta.	'	
INPACTENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days)		I NPATI ENT DAYS				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 4.00 Semi-private room days (excluding saing-bed and observation bed days). 5.634 4.00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line). 7.00 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line). 7.00 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost reporting period (if call ender year, enter 0 on this line). 8.00 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost reporting period (including year, enter 0 on this line). 9.00 Total inputient days including private room days applicable to the Program (excluding swing-bed and newborn days). 10.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after on through Becember 31 of the cost reporting period (it its XVIII only (including private room days) after through Becember 31 of the cost reporting period (it its XVIII only (including private room days) after on through Becember 31 of the cost reporting period (it its XVIII only (including private room days) after on through Becember 31 of the cost reporting period (it its XVIII only (including private room days) after on through Becember 31 of the cost reporting period (it its XVIII only (including private room days) after becember 31 of the cost reporting period (it its XVIII only (including private room days) after becember 31 of the cost reporting period (it in XVIII only (including private room days) after becember 31 of the cost reporting period (it in XVIII only (including private room days) after becember 31 of the cost reporting period (it in XVIII only including private room days) after becember 31 of the cost repo						
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Heal th	Financial Systems LL	THERAN MUSCULOSKI	ELETAL CENTEI	R	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-0168	Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	5/31/2018 12: Cost	17 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost In	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	C				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	C	0.0	00 0	0	43. 00
44. 00	CORONARY CARE UNIT		C				44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	C	1		0	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	0	C	0.0	00	0	46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)		61, 424 359, 975	•
49.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40) (se	ee mstructro) is)		337, 773	49.00
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	n Wkst. D, sur	n of Parts I and	0	50. 00
51. 00	<pre> </pre>	atient ancillary	services (fr	om Wkst D s	sum of Parts II	0	51. 00
01.00	and IV)	,	30. 7. 303 (5 III.5 C. 57 C	Jam		011.00
52.00	Total Program excludable cost (sum of lines	,	tod non nh	ici ci an ancath	natiot and	0	52.00
53. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		atea, non-pny	/Siciali allesti	ietist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	56.00
57. 00		ing cost and targ	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period er	ndina 1996 u	indated and co	omnounded by the	0 00	58. 00 59. 00
37.00	market basket	portring perrod er	idi ilg 1770, C	apuateu anu co	silipourided by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the emount by	0.00	
61. 00	which operating costs (line 53) are less than					0	61. 00
	amount (line 56), otherwise enter zero (see			,	3	_	
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistruct	11 0113)				03.00
64. 00		ts through Decemb	oer 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the c	cost reportino	period (See	0	65. 00
	instructions) (title XVIII only)				, ,	_	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	1 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	1 '	e costs through D	December 31 d	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19)	o costs after Doc	combor 21 of	the cost rone	orting ported	_	68. 00
00.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after bed	Lelliber 31 01	the cost repo	of tring period		08.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (lir					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ling 14 v li	no 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74. 00
75. 00	Capital -related cost allocated to inpatient	routine service d	costs (from V	Vorksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	•					77. 00
78.00	Inpatient routine service cost (line 74 minu			do)			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		· ·	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on		,	,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .	1				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	,	•				84. 00
85.00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ough 85)				86. 00
87. 00						307	87. 00
88. 00	, , , , , , , , , , , , , , , , , , , ,	•	ine 2)			915. 80	
07.00	Observation bed cost (line 87 x line 88) (se	e mstructions)				281, 151	09.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	!	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	547, 162	5, 440, 746	0. 10056	7 281, 151	28, 275	90. 00
91.00 Nursing School cost	0	5, 440, 746	0.00000	0 281, 151	0	91.00
92.00 Allied health cost	0	5, 440, 746	0.00000	0 281, 151	0	92.00
93.00 All other Medical Education	0	5, 440, 746	0.00000	0 281, 151	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	?	In Lie	u of Form CMS-2	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2017	Worksheet D-3	
			To 12/31/2017	Date/Time Pre 5/31/2018 12:	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Innatient	Innatient	

				rom 01/01/2017 o 12/31/2017	Date/Time Prep	
		Title X	VIII	Hospi tal	5/31/2018 12: PPS	т ріп
	Cost Center Description	Ra	atio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col.	
		_	1 00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1. 00	2. 00	3. 00	
	03000 ADULTS & PEDI ATRI CS			2, 976, 874		30. 00
	03100 INTENSIVE CARE UNIT			0		31.00
	03200 CORONARY CARE UNIT			0		32. 00
	03300 BURN INTENSIVE CARE UNIT			0		33. 00
	03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF			0		40. 00 41. 00
	04300 NURSERY			U		43.00
	ANCI LLARY SERVI CE COST CENTERS					43.00
	05000 OPERATING ROOM		0. 091919	30, 896, 674	2, 839, 991	50. 00
51. 00	05100 RECOVERY ROOM		0. 028100	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 000000		0	52.00
	05300 ANESTHESI OLOGY		0. 000000		0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 080591	885, 223	71, 341	54.00
	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C		0.042013	0	0	54. 01 55. 00
	05600 RADI OLOGY - THERAPEUTI C		0. 000000 0. 000000	0	0	56. 00
	05700 CT SCAN		0. 627534	0	0	57. 00
	05800 MRI		0. 072508	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON		0. 000000	0	0	59. 00
60. 00	06000 LABORATORY		0. 109354	1, 439, 588	157, 425	60.00
60. 01	06001 BLOOD LABORATORY		0.000000	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000	0	0	61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 000000	0	0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	63. 00
	06400 I NTRAVENOUS THERAPY		0.000000		6 300	64. 00 65. 00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 039565 0. 301051	159, 229 1, 546, 959	6, 300 465, 714	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 000000		0	67. 00
	06800 SPEECH PATHOLOGY		0. 000000		0	68. 00
	06900 ELECTROCARDI OLOGY		0. 060577	108, 183	6, 553	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.000000	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 039026		168, 133	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 130834	33, 982, 976	4, 446, 129	72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 043637	5, 158, 011	225, 080	73. 00
	07400 RENAL DIALYSIS		0.000000		0	74. 00
	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS		0. 000000	0	0	75. 00
	08800 RURAL HEALTH CLINIC		0. 000000		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		0	89. 00
	09000 CLI NI C		0.000000	0	0	90.00
91. 00	09100 EMERGENCY		0.000000	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 500004	12, 635	6, 318	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DI ALYSI S		0. 000000	0	0	
	09500 AMBULANCE SERVI CES		0.000000	0	0	95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD		0. 000000 0. 000000		0	96. 00 97. 00
	09850 OTHER REIMBURSABLE COSTS		0. 000000		0	97. 00 98. 00
200.00			3. 000000	78, 497, 711	8, 392, 984	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202. 00				78, 497, 711		202. 00
		·		·		

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0168	Peri od:	Worksheet D-3

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	R	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D-3	
				5/31/2018 12:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	•	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1 00	0.00	2)	
INDATION DOUTING CODY OF COCT CONTEDC		1.00	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS			212 240	1	30.00
31. 00 03100 NTENSI VE CARE UNIT			212, 349		31.00
1 I					32.00
1 I					1
1 I					33.00
1 I					40.00
					1
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 04300 NURSERY			0	1	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 09191	0 210 204	28, 514	50.00
1 I		1			1
51. 00 05100 RECOVERY ROOM		0. 02810		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		_	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 08059		769	1
54. 01 03630 ULTRA SOUND		0. 04201		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
56. 00 05600 RADI OI SOTOPE		0.00000		0	56.00
57. 00 05700 CT SCAN		0. 62753		0	
58. 00 05800 MRI		0. 07250		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60. 00 06000 LABORATORY		0. 10935			
60. 01 06001 BLOOD LABORATORY		0.00000		0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		_	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		_	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		_	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		_	
65. 00 06500 RESPIRATORY THERAPY		0. 03956			1
66. 00 06600 PHYSI CAL THERAPY		0. 30105			1
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	
68. 00 06800 SPEECH PATHOLOGY		0.00000		_0	
69. 00 06900 ELECTROCARDI OLOGY		0. 06057		_	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 03902		l .	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13083		22, 373	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.04363			1
74. 00 07400 RENAL DI ALYSI S		0.00000			1
75. 00 O7500 ASC (NON-DISTINCT PART)		0.00000	00 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS		1 0 00000	20	1 0	00.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000			
90. 00 09000 CLI NI C		0.00000		_	
91. 00 09100 EMERGENCY		0.00000			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 50000	04 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS			-	-	
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	00	0	
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	
98.00 09850 OTHER REIMBURSABLE COSTS		0.00000		0	
200.00 Total (sum of lines 50 through 94 ar			593, 280	61, 424	200. 00
201. 00 Less PBP Clinic Laboratory Services-			0	1	201. 00
202.00 Net charges (line 200 minus line 201	1)	1	593, 280	1	202. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/31/2018 12:17 pm

			10 12/31/2017	5/31/2018 12:	
		Title XVIII	Hospi tal	PPS	
			•		
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (:	see	7, 468, 213	1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurri	ing on or after October	1 (see	2, 368, 741	1. 02
	instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	orior to October	0	1. 03
4 04	1 (see instructions)		61	0	4 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring (on or atter	0	1. 04
2 00	October 1 (see instructions)			0	2 00
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2. 01	Outlier reconciliation amount	(ana)		0	2. 01 2. 02
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructi	OIIS)		0	3. 00
4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	sting pariod (see instru	ations)	-	4. 00
4.00	Indirect Medical Education Adjustment	tring period (see riistru	LI OHS)	38. 16	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	port od onding on	0.00	5. 00
5.00	or before 12/31/1996. (see instructions)	recent cost reporting	berrou enaing on	0.00	3.00
6. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add-	on to the can	0. 00	6. 00
0.00	for new programs in accordance with 42 CFR 413.79(e)	the erreerra for all add t	on to the cap	0.00	0.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	inder 42 CFR §412 105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0. 00	7. 01
,, , , ,	cost report straddles July 1, 2011 then see instructions.	12 0111 31121 100(1)(1)(1	.,(5)(2)	0.00	,
8. 00	Adjustment (increase or decrease) to the FTE count for allopations	thic and osteopathic pro	grams for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.				
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8.02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospi tal	0.00	8. 02
	under § 5506 of ACA. (see instructions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (see	0.00	9. 00
	instructions)				
	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds		10. 00
	FTE count for residents in dental and podiatric programs.				11. 00
	Current year allowable FTE (see instructions)			0. 00	
	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that yea	ar ended on or after Sep	tember 30, 1997,	0. 00	14. 00
45.00	otherwise enter zero.				45 00
	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count			0.00	
	Current year resident to bed ratio (line 18 divided by line 4)).		0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	21. 00 22. 00
	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions)	of the MMA		0	22. 01
33 00	Indirect Medical Education Adjustment for the Add-on for § 422		ED /12 105	0.00	23. 00
Z3. UU	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	ent cap stots under 42 Cl	IN 412. 100	0.00	23.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
	If the amount on line 24 is greater than -0-, then enter the I	lower of line 23 or line	24 (500	0.00	
23.00	instructions)	Tower of Time 25 of Time	24 (366	0.00	23.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
			0	28. 01	
	Total IME payment (sum of lines 22 and 28)	,		0	29. 00
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
	Di sproporti onate Share Adjustment				
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	3. 43	30. 00
	Percentage of Medicaid patient days (see instructions)		-/	0. 00	
	Sum of lines 30 and 31			3. 43	
	Allowable disproportionate share percentage (see instructions))		0. 00	
	Disproportionate share adjustment (see instructions)				34.00
			'		

	Financial Systems LUTHERAN MUSCULOSK ATION OF REIMBURSEMENT SETTLEMENT	ELETAL CENTER Provider CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet E	200Z-I
07.12002			From 01/01/2017 To 12/31/2017	Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2018 12: PPS	17 pm
		II LIE AVIII	Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0] 35. 00
35. 00	,		0. 000000000	0. 000000000	
35. 02		er zero on this line) (se		0	1
25 02	instructions)	ount (coo i notruptions)	0	0	25 0
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment am Total uncompensated care (sum of columns 1 and 2 on line 35.0	,	0	0	35. 00 36. 00
	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu			
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40.00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683. 684 an 685. (see	0		41.0
00	instructions)	300, 30. a 300. (300			
41. 01	1 9 9	-DRGs 652, 682, 683, 684	0		41.0
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42. 0
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 66		1		43. 0
44.00	instructions)		0.00000		
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.0
45. 00	Average weekly cost for dialysis treatments (see instructions		0. 00		45. 0
46. 00	Total additional payment (line 45 times line 44 times line 4	1. 01)	0		46.0
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	9, 836, 954		47. 0 48. 0
10. 00	only. (see instructions)	Smarr rarar nosprtars	Ŭ		10.0
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions	5)		1. 00 9, 836, 954	49. 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			789, 393	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	ine 49 see instructions).		0	52. 0 53. 0
54. 00	Special add-on payments for new technologies			0	54.0
54. 01	Islet isolation add-on payment	(3)		0	54.0
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see integral of the cost of physicians).	•		0	
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	•	hrough 35).	0	57.0
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
59. 00 50. 00	Total (sum of amounts on lines 49 through 58)			10, 626, 347 9, 333	
61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	s line 60)		10, 617, 014	
52. 00	Deductibles billed to program beneficiaries	,		929, 614	
63.00	Coinsurance billed to program beneficiaries			9, 158	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			36, 356 23, 631	1
66.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		21, 107	
57. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9, 701, 873	1
8. 00	Credits received from manufacturers for replaced devices for			0	1
59. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOR SCH See FIISTRUCTION	15)	0	70.0
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	1
70. 87	Demonstration payment adjustment amount before sequestration			0	1
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70.8
70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	ti ucti ulis <i>j</i>		0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 9
70. 92	Bundled Model 1 discount amount (see instructions)			77.027	70. 9
70. 93	, , ,			77, 937 0	1
70. 94					

Health Financial Systems LUTHERAN	MUSCULOSKELETAL CENTE	R	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/31/2018 12:	
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy			0	0	70. 96

			5/31/2018 12:	17 pm
	Title XVIII	Hospi tal	PPS	
		FFY (yyyy)	Amount	
		0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0	0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the period ending of the period en		0	0	70. 97
70. 98 Low Volume Payment-3	ei 10/1)		0	70. 98
70. 99 HAC adjustment amount (see instructions)			26, 021	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	0 8 70)		9, 753, 789	
71.00 Amount due provider (Time 67 minus Times 68 pros/minus Times 67 minus Times 68 pros/minus Times 68 p	19 & 70)			
			195, 076	
71.02 Demonstration payment adjustment amount after sequestration			0 505 07/	
72.00 Interim payments			9, 535, 976	
73.00 Tentative settlement (for contractor use only)	- 70		0	
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02	., 72, and		22, 737	74. 00
73)				
75.00 Protested amounts (nonallowable cost report items) in accordar CMS Pub. 15-2, chapter 1, §115.2	ce with		128, 302	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	ructions)		0	
91.00 Capital outlier from Wkst. L, Pt. I, line 2			0	91. 00
92.00 Operating outlier reconciliation adjustment amount (see instru	ctions)		0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruct	i ons)		0	93. 00
94.00 The rate used to calculate the time value of money (see instru	ctions)		0.00	94.00
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 instruct	i ons)		0	96.00
		Prior to 10/	1 On/After 10/1	
		1. 00	2.00	
HSP Bonus Payment Amount				
100.00 HSP bonus amount (see instructions)			0 0	100.00
HVBP Adjustment for HSP Bonus Payment		<u> </u>	-1	1
101.00 HVBP adjustment factor (see instructions)		0.00000000	0. 000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0.0000000		102.00
HRR Adjustment for HSP Bonus Payment	'/	I	0 0	102.00
103. 00 HRR adjustment factor (see instructions)		0.000	0 0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)		0.000		104. 00
Rural Community Hospital Demonstration Project (\$410A Demonstr			0 0	1104.00
200.00 Is this the first year of the current 5-year demonstration per				200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.	Tod dilder the 21st			200.00
Cost Reimbursement		I		
201. 00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line				201. 00
202. 00 Medicare di scharges (see instructions)	49)			202.00
203.00 Case-mix adjustment factor (see instructions)				202. 00
Computation of Demonstration Target Amount Limitation (N/A in	first year of the s	urrent E veer demon	ctration	203.00
period)	irrst year or the c	urrent 5-year dellon	Stration	
204. 00 Medi care target amount				204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)				204.00
206. 00 Medicare inpatient routine cost cap (line 202 times line 205)				206. 00
				206.00
Adjustment to Medicare Part A Inpatient Reimbursement				207.00
207.00 Program reimbursement under the §410A Demonstration (see instr				207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	11ne 59)			208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)				209. 00
210.00 Reserved for future use				210. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions)				211. 00
Comparision of PPS versus Cost Reimbursement				
212.00 Total adjustment to Medicare Part A IPPS payments (from line 2	11)			212. 00
213.00 Low-volume adjustment (see instructions)				213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS ar	d cost reimbursemen	t)		218. 00
(line 212 minus line 213) (see instructions)				

| Peri od: | Worksheet E | From 01/01/2017 | Part A Exhibit 5 | Date/Time Prepared: | To 12/31/2017 | Part A Exhibit 5 | Part A Heal th FinancialSystemsLUTHERAN MUSCULOSEHOSPITALACQUIREDCONDITION (HAC)REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0168

				T	o 12/31/2017	Date/Time Prep 5/31/2018 12:	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	7, 468, 213	7, 468, 213		7, 468, 213	1. 01
1 00	discharges occurring prior to October 1	1 00	2 2/0 7/1		2 2/0 7/1	2 2/0 7/1	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 368, 741		2, 368, 741	2, 368, 741	1. 02
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
1.03	for Model 4 BPCI occurring prior to October	1.03		O		J	1.03
	1						
1.04	DRG for Federal specific operating payment	1. 04	О		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	0	0	0	0	2. 00
	instructions)						
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	Ü	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3.00	0	0	0		4. 00
1. 00	Indirect Medical Education Adjustment	0.00	<u> </u>	<u> </u>		0	1. 00
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.000000	0. 000000		5. 00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	INSTRUCTIONS) IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01		0	0		8. 01
0.01	care (see instructions)	20.01		J	O		0.01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	o	0	0	o	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	o	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0.0000	0. 0000	0. 0000		10. 00
44.00	(see instructions)	24.00		0			44.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11. 00
11. 01	Uncompensated care payments	36.00	0	0	0	0	11. 01
11.01	Additional payment for high percentage of ESF			<u> </u>			11.01
12.00	Total ESRD additional payment (see	46.00	0	0	0	0	12. 00
	instructions)						
13.00	Subtotal (see instructions)	47.00	9, 836, 954	7, 468, 213	2, 368, 741	9, 836, 954	13.00
14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
45.00	instructions)	40.00	0.007.054	7 4/0 040	0 0/0 744	0.007.054	45.00
15. 00	Total payment for inpatient operating costs	49. 00	9, 836, 954	7, 468, 213	2, 368, 741	9, 836, 954	15. 00
16 00	(see instructions) Payment for inpatient program capital (from	50.00	789, 393	556, 020	233, 373	789, 393	16. 00
10.00	Wkst. L, Pt. I, if applicable)	30.00	707, 373	330, 020	233, 373	707, 373	10.00
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	17. 00
17. 01	Net organ acquisition cost	2 00		Ü	· ·		17. 01
17. 02	Credits received from manufacturers for	68. 00	o	0	0	0	17. 02
	replaced devices for applicable MS-DRGs						
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
40	amount (see instructions)						40
19.00	SUBTOTAL			8, 024, 233	2, 602, 114	10, 626, 347	19.00

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CEN	ITER		In Lieu of Form CMS-2552-10
HOODI TALL ACCUILDED CONDITION (HA	0) DEBUGELON ON OUR ATLON EXCURIT		0.011 45 0440	Tp	

Heal th	Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	?	In Li€	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der Co	CN: 15-0168	Period: From 01/01/2017	Worksheet E Part A Exhi bi	+ 5
					To 12/31/2017		
					.0 12,01,201,	5/31/2018 12:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line					
		_	Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	789, 393	556, 02	233, 373		
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0	0	20. 01
21. 00	Capital DRG outlier payments	2.00	0		0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage	10.00	0.0000	0.000	0.0000		24. 00
24.00	(see instructions)	10.00	0.0000	0.000	0.0000		
25. 00	Disproportionate share adjustment (see instructions)	11.00	0		0	0	25. 00
26. 00	Total prospective capital payments (see	12. 00	789, 393	556, 02	233, 373	789, 393	26. 00
	instructions)	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		A, TITIC	A)				
		0	1, 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	77, 937	77, 93	7 0	77, 937	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	,	0 0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0		0 0	0	31. 01
	instructions)						
						(Amt. to Wkst.	
			1.00		0.00	E, Pt. A)	
22.00	UAC Deduction Decrees adjustment (0	1.00	2. 00	3. 00	4. 00	22.00
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 26, 021	26, 021	32. 00
100, 00	Transfer HAC Reduction Program adjustment to		Y				100. 00
	Wkst. E, Pt. A.						
		•	•	•	•	•	

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	Peri od: Worksheet E From 01/01/2017 Part B To 12/31/2017 Date/Ti me Prepared: 5/31/2018 12:17 pm

		10 12/31/201/	5/31/2018 12:	
		Title XVIII Hospital	PPS	17 piii
		THE WITTER TO SET US.	1	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		1, 403	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)	3, 265, 793	
3. 00	OPPS payments		3, 847, 633	
4.00	Outlier payment (see instructions)		5, 415	
4. 01	Outlier reconciliation amount (see instructions)		0	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	5. 00
6.00	Line 2 times line 5	•	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1, 403	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonabl e charges			
12.00	Ancillary service charges		32, 157	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		32, 157	14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.	payment for services on a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	r payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(6	e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17. 00
18. 00	Total customary charges (see instructions)		32, 157	
19. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds line 11) (see	30, 754	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds line 18) (see	0	20. 00
	instructions)			
21. 00	Lesser of cost or charges (see instructions)			21. 00
22. 00	Interns and residents (see instructions)		0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		3, 853, 048	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		24 504	25 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)	r CAH coo instructions)	24, 504	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for		686, 316 3, 143, 631	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions	prus tile suiii or rriies 22 and 23] (see	3, 143, 031	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	1116 30)	0	
30.00	Subtotal (sum of lines 27 through 29)		3, 143, 631	
31. 00	Primary payer payments		0	
32. 00	Subtotal (line 30 minus line 31)		3, 143, 631	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	· · · · ·	0	33. 00
34.00	Allowable bad debts (see instructions)		78, 464	
35.00	Adjusted reimbursable bad debts (see instructions)		51, 002	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	68, 229	
37.00	Subtotal (see instructions)		3, 194, 633	37. 00
38.00	MSP-LCC reconciliation amount from PS&R		0	38. 00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	39. 99
40.00	Subtotal (see instructions)		3, 194, 633	40.00
40. 01	Sequestration adjustment (see instructions)		63, 893	40. 01
40.02	Demonstration payment adjustment amount after sequestration		0	40. 02
41.00	Interim payments		3, 080, 505	41.00
42.00	Tentative settlement (for contractors use only)		0	42. 00
43.00	Balance due provider/program (see instructions)		50, 235	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2	·		
	TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91. 00
92. 00	The rate used to calculate the Time Value of Money		0.00	
93. 00	Time Value of Money (see instructions)		0	
94.00	Total (sum of lines 91 and 93)		0	94. 00

Heal th Financial Systems

LUTHERAN MUSCULOSKELETAL CENTER

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0168
Period:
From 01/01/2017
To 12/31/2017
Part I
Date/Time Prepared:
5/31/2018 12: 17 pm
PPS

Inpatient Part A
Part B

		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	11.00	9, 535, 976	0.00	3, 080, 505	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for		_			
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3. 04			0		0	3. 04
3.05			0		0	3. 05
0.50	Provi der to Program					0.50
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52 3. 53] 0 0			3. 52 3. 53
3. 53			0			3. 53 3. 54
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 54 3. 99
3. 99	3. 50-3. 98)		0			3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 535, 976		3, 080, 505	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		7, 555, 776		3,000,505	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	ļ.				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program	Г	_		_	
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
4 00						6. 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		22, 737		50, 235	6. 01
6. 02	SETTLEMENT TO PROGRAM		22, 737		30, 233	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 558, 713		3, 130, 740	7. 00
7.00	Trotal mode ode o program trability (ode thotal detroits)		7,000,710	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•	. '	

Heal th	Financial Systems LUTHERAN MUSCULOSKE	ELETAL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017		pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	: 14		1. 00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00	
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168 $$	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Polance due provider (line 0 (er line 10) minus line 20 and l	ing 21) (and improved on)		22 00

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

30. 00 31. 00 32. 00

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0168	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/31/2018 12:17 pm

		Title XVIII	Hospi tal	5/31/2018 12: PPS	1/ pm
		THE XVIII	1103pi tui	113	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			0	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0	3. 00
4.00	Outlier Payments			0	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent co to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE country program or hospital closure, that would not be counted without			0. 00	5. 01
6. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)			0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7. 00
	teaching program" (see instructions)				
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			15. 435616	10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			0	13.00
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	16. 00
17. 00	Subtotal (see instructions)			0	17. 00
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			0	19. 00
20. 00	Deducti bl es			0	20. 00
21. 00	Subtotal (line 19 minus line 20)			0	21. 00
22. 00	Coinsurance			0	22. 00
23. 00	Subtotal (line 21 minus line 22)			0	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)			0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)			26. 00
27. 00 28. 00	Subtotal (sum of lines 23 and 25)	no 40)		0	27. 00 28. 00
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	28.00
30. 00	Other pass through costs (see instructions) Outlier payments reconciliation			0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	=)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	3)		Ö	31. 99
32. 00	Total amount payable to the provider (see instructions)			Ö	32. 00
32. 01	Sequestration adjustment (see instructions)			0	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33. 00	Interim payments			9, 535, 976	33. 00
34.00	Tentative settlement (for contractor use only)			0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	2. 33. and 34)		-9, 535, 976	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordan	•	chapter 1,	0	36. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51. 00
52.00	The rate used to calculate the Time Value of Money			0.00	52.00
53. 00	Time Value of Money (see instructions)			0	53. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2018 12:17 pm

			lo 12/31/2017	Date/lime Pre 5/31/2018 12:	
		Title XIX	Hospi tal	Cost	., p
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		359, 975		1.00
2.00	Medical and other services			99, 691	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		359, 975	99, 691	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		359, 975	99, 691	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		593, 280	986, 720	9. 00
10. 00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		593, 280	986, 720	12.00
40.00	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14.00	basis		0	0	14 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		593, 280	986, 720	1
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	233, 305	887, 029	1
17.00	line 4) (see instructions)	y 11 1111c 10 exceeds	255, 505	007,027	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	(6)	359, 975	99, 691	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		359, 975	99, 691	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		359, 975	99, 691	
32.00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions) Utilization review		0	Ü	34. 00 35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	359, 975	99, 691	
	PPS PAYMENT METHODOLOGY UPDATE	1 33)	-359, 976	-99, 693	1
	Subtotal (line 36 ± line 37)		-337, 770	-77, 073	1
	Direct graduate medical education payments (from Wkst. E-4)		0	-2	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		-1	-2	1
41. 00	Interim payments		0	-2	•
42. 00	Balance due provider/program (line 40 minus line 41)		-1	-2	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	
50	chapter 1, §115.2			· ·	
			'		

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

Provider CCN: 15-0168

Peri od: From 01/01/2017 To 12/31/2017 Worksheet G

Date/Time Prepared: 5/31/2018 12:17 pm onl y)

		General Fund	Speci fi c	Endowment Fund	Plant Fund	ı / pili
			Purpose Fund			
	CURRENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	-1, 288, 769	0	ol	0	1. 00
2. 00	Temporary investments	0	1	Ö	0	2. 00
3.00	Notes recei vabl e	0	0	o	0	3. 00
4.00	Accounts receivable	19, 973, 492	0	0	0	4. 00
5.00	Other receivable	0	0	0	0	5. 00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-1, 627, 281 1, 539, 536		0	0	6. 00 7. 00
8.00	Prepaid expenses	212, 621		0	0	
9. 00	Other current assets	54, 611		Ö	0	
10.00	Due from other funds	0	0	О	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	18, 864, 210	0	0	0	11. 00
10.00	FI XED ASSETS			ol	0	10.00
12. 00 13. 00	Land Land improvements	0 26, 765		ol Ol	0	12. 00 13. 00
14. 00	Accumulated depreciation	-12, 134		0	0	1
15. 00	Bui I di ngs	12, 981		ō	0	1
16.00	Accumulated depreciation	-2, 777	0	o	0	16. 00
17. 00	Leasehold improvements	3, 193, 542		0	0	
18.00	Accumulated depreciation	-280, 138		0	0	•
19. 00 20. 00	Fixed equipment Accumulated depreciation	429, 424 -209, 896		0	0	19. 00 20. 00
21. 00	Automobiles and trucks	28, 303		0	0	21.00
22. 00	Accumulated depreciation	-20, 989		Ö	0	22. 00
23. 00	Maj or movable equipment	9, 466, 926	0	o	0	23. 00
24. 00	Accumulated depreciation	-6, 797, 752		0	0	
25. 00	Mi nor equipment depreciable	1, 750, 051		0	0	ł
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-1, 259, 306	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	o o	Ö	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	6, 325, 000	0	0	0	30. 00
	OTHER ASSETS	1				
31.00	Investments	0		0	0	
32. 00 33. 00	Deposits on Leases Due from owners/officers	0	0	0	0	
34. 00	Other assets	1, 147, 054	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	1, 147, 054		o	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	26, 336, 264		О	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	3, 451, 474		0	0	•
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	1, 518, 718		0	0	
40. 00	Notes and Loans payable (short term)	126, 514 94, 445		0	0	
41. 00	Deferred income	0	ő	Ö	0	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	-272, 941, 298		0	0	43. 00
44. 00	Other current liabilities	752, 881		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	-266, 997, 266	0	U	0	45. 00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable	145, 833		Ö	0	
48. 00	Unsecured Loans	0	0	o	0	1
49. 00	Other long term liabilities	38, 359, 485		0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	38, 505, 318		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	-228, 491, 948	0	0	0	51. 00
52. 00	General fund balance	254, 828, 212				52. 00
53. 00	Speci fi c purpose fund	254, 020, 212	0			53.00
54.00	Donor created - endowment fund balance - restricted			О		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	254, 828, 212	o	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	26, 336, 264		ō	0	ł
	[59]	l]			

Provider CCN: 15-0168

					10 12/31/201/	5/31/2018 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
				•			
		1.00	0.00	0.00	4.00	F 00	
1.00	Fund balances at beginning of period	1.00	2. 00 227, 432, 944	3. 00	4. 00	5. 00	1, 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		27, 395, 169			'	2.00
3.00	Total (sum of line 1 and line 2)		254, 828, 113			,	3. 00
4. 00	SERIOUS EDIT ADJUSTMENT	99	254, 020, 115		0	O	4. 00
5. 00	DEM GGG EST TASSGGTMENT	0			o	0	5. 00
6.00		O			0	0	6. 00
7.00		O			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		99		C)	10. 00
11. 00	Subtotal (line 3 plus line 10)		254, 828, 212		C)	11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13. 00		0			0	0	13. 00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16.00		0			0	0	16. 00
17. 00	T-+-1	0	0		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		054 000 010			(18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		254, 828, 212			'	19. 00
	Taricet, (Title 11 millids 11 he 10)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00	Total (sum of line 1 and line 2)	0	_		0		3. 00
4.00	SERIOUS EDIT ADJUSTMENT		0				4. 00
5.00			0				5. 00
6.00			0				6.00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0	U		0		10.00
11. 00	Subtotal (line 3 plus line 10)				0		11.00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13. 00	boddetrons (debrt day detiments) (speerry)		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			o				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)						

Health Financial Systems LUTH-STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0168

			To	12/31/2017	Date/Time Prep 5/31/2018 12:	
	Cost Center Description	1	npati ent	Outpati ent	Total	17 рііі
	Social Social Person		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	I	11.00	2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		9, 655, 778		9, 655, 778	1. 00
2.00	SUBPROVIDER - I PF		0		0	2. 00
3.00	SUBPROVI DER - I RF		0		0	3. 00
4.00	SUBPROVI DER		_		-	4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9. 00	OTHER LONG TERM CARE		0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		9, 655, 778		9, 655, 778	
	Intensive Care Type Inpatient Hospital Services		77 0007 770		7,000,770	10.00
11. 00	INTENSIVE CARE UNIT		0		0	11. 00
12. 00	CORONARY CARE UNIT		Ō		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0		0	
14. 00	SURGI CAL INTENSIVE CARE UNIT		0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)		J		ŭ.	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Lines	0		0	
	11-15)		J		ŭ	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		9, 655, 778		9, 655, 778	17. 00
18. 00	Ancillary services		228, 186, 644	0	228, 186, 644	
19. 00	Outpatient services		0	239, 590, 637	239, 590, 637	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22. 00	HOME HEALTH AGENCY		_	0	0	22. 00
23. 00	AMBULANCE SERVICES		0	o	0	23. 00
24. 00	CMHC			o	0	24. 00
24. 10	CORF		0	o	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	o	0	25. 00
26. 00	HOSPI CE		0	o	0	26. 00
27.00	OTHER (SPECIFY)		0	o	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	237, 842, 422	239, 590, 637	477, 433, 059	
	G-3, line 1)				,,	
	PART II - OPERATING EXPENSES	•				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			78, 656, 428		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39.00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		78, 656, 428		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0168	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared:
			10 12/31/2017	5/31/2018 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Par			477, 433, 059	
2.00	Less contractual allowances and discounts of	n patients' accounts		371, 487, 296	
3.00	Net patient revenues (line 1 minus line 2)			105, 945, 763	
4.00	Less total operating expenses (from Wkst. G			78, 656, 428	
5.00	Net income from service to patients (line 3	minus line 4)		27, 289, 335	5. 00
	OTHER INCOME				1
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			0	
8.00	Revenues from telephone and other miscellar	eous communication services		0	
9.00	Revenue from television and radio service			0	1
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and gu	ests		0	1
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical s			0	16. 00
17. 00	Revenue from sale of drugs to other than pa	tients		0	17. 00
18. 00	Revenue from sale of medical records and ab	stracts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER INCOME			105, 834	24. 00
05 00	T			405 004	1 05 00

0 27. 00

27, 395, 169 29. 00

25.00 26. 00

28. 00

105, 834 27, 395, 169

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

27. 00 OTHER EXPENSES (SPECIFY)

	Financial Systems LUTHERAN MUSCULOSKE			u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0168	Peri od: From 01/01/2017	Worksheet L Parts I-III	
			To 12/31/2017	Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2018 12: PPS	1/ pm
		II tile XVIII	поѕрі таі	PP3	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			789, 393	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			0	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	15. 44	
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0. 00	•
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01)(see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p. 30) (see instructions)	atient days (Worksheet E	E, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instru	ctions)		0.00	
9.00	Sum of lines 7 and 8			0. 00	
10.00	Allowable disproportionate share percentage (see instructions)		0. 00	
11. 00	Disproportionate share adjustment (see instructions)			0	11.00
12. 00	Total prospective capital payments (see instructions)			789, 393	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
	Total inpatient program capital cost (line 1 plus line 2)				
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total Tripatient program capital cost (Trie 3 x Trile 4)			0	3.00
				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0. 00 0	
5.00	Capital cost for comparison to payments (line 3 x line 4)	ctructions)		-	
6. 00 7. 00	Percentage adjustment for extraordinary circumstances (see in Adjustment to capital minimum payment level for extraordinary		(line 6)	0. 00 0	
8. 00	Capital minimum payment level (line 5 plus line 7)	CITCUIIS LATICES (TITIE 2 X	CITIE 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as appli	cahl e)		0	
10.00	Current year comparison of capital minimum payment level to c		less line 0)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over c			0	
. 1. 00	Worksheet L, Part III, line 14)	aprear payment (110m pri	or year		' ' ' ' '
12. 00	Net comparison of capital minimum payment level to capital pa	yments (line 10 plus lir	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13. 00
14.00	Carryover of accumulated capital minimum payment level over c			0	14. 00
	(if line 12 is negative enter the amount on this line)				ı

15.00 0 16.00 0 17.00

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

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