AND SETTLEMENT	SUMMARY		From 01/01/2018 Parts I-III To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm
PART I - COST	REPORT STATUS		
Provi der use only	 [X] Electronically filed cost report [] Manually submitted cost report [0] If this is an amended report enter the number [F] Medicare Utilization. Enter "F" for full or "L 		Date: 5/30/2019 Time: 3:48 pm er resubmitted this cost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit (4) Reopened (5) Amended	or this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. [0]If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 01/01/2018 and ending 12/31/2018 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)
Title
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	7, 992	52, 882	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	7, 992	52, 882	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

	reporting period? In column 2, enter "Y" for yes or	N TOT NO.						
		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	
		pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			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	0	0	0	0	0	0	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.							

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IUSCULOSKELE TA I	Provi der CC		Peri od:				n CMS-2 et S-2	
						/31/20	18 Da 57	<u> 30/20</u>	me Prei 19 3:48	pared 8 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaic eligible unpaid	HMO	i cai d days	Med d	her i cai d ays	
00	If this provider is an IRF, enter the in-state	1.00	2. 00	3.00	4. 00	0 5	. 00	6	. 00	25.
. 00	Medicaid paid days in column 1, the in-state 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.	0	0	0	Unhous				Cooper	25.
						/Rural 1.00	3 Da	2.0		
. 00	Enter your standard geographic classification (not wa	age) status	at the beg	inning of t			1			26.
	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 enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in o	ural. If ap column 2.	ppl i cabl e,			1			27.
. 00	If this is a sole community hospital (SCH), enter the	e number of	periods SC	CH status in			0			35.
	effect in the cost reporting period.				Begi	nni ng:		Endi ı	ng:	
				0/ 6		1. 00		2.0		
UU	Enter applicable beginning and ending dates of SCH store of periods in excess of one and enter subsequent date		cript line	36 TOT NUMB	er					36
00	If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	s		0			37
01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions.									37
00	instructions) 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
	ontor Subsequent dates.					Y/N		1\Y	V	
00	Door this facility gualify for the impatient beautal	normant a	dinatmant f	For Low Volu		1. 00 N		2. 0 N	0	20
.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	ın	N		IN		39
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			Υ	V	Υ	VIV	40
								(VIII 2. 00	XI X 3. 00	
	Prospective Payment System (PPS)-Capital									
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	•			ce	N N	N N	N N	45
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	II and Wkst	. L-1, Pt.	I through	۱				
00	ls this a new hospital under 42 CFR §412.300(b) PPS o						N	N	N	47
	Is the facility electing full federal capital payment Teaching Hospitals						N	N	N	48
00	Is this a hospital involved in training residents in or "N" for no.		. 0		,		N			56
00	If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monifor yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N" th of this of ", complete	"for no in cost report e Worksheet	n column 1. ing period?	If column 'Enter'	'Y"				57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, chapter 21, §2148? If yes,			ıns' servi ce	s as					58
	Are costs claimed on line 100 of Worksheet A? If yes						N L			59
				NAHE 413.8 Y/N		sheet ne #	Qu		cation	
							Cri	terro	n Code	
				1. 00		2. 00	Cri	3.0		

Health Financial Systems LUTHERAN M	IISCIII OSI	KELETAL CENTER	?	Inlie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC	CN: 15-0168 F	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I	pared:
	Y/N	IME	Direct GME	IME	Direct GME	5 pili
	1.00	2. 00	3. 00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	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 instructions)						61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pro	ogram Name	Program Code		Unweighted Direct GME FTE Count	
(4.40.05.11.575.1.1.1.4.05		1. 00	2. 00	3.00	4.00	(1.10
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
61.20 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.				0.00	0.00	61. 20
ACA Descisions Affordism the Health Description of Co.			(UDCA)		1.00	
ACA Provisions Affecting the Health Resources and Sel 62.00 Enter the number of FTE residents that your hospital	trai ned			iod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction for the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC process.)	a Teachi gram. (s	ee instruction		your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co		uctions)	N	63. 00
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	

	Noribi ovi dei	i nospitai j		
	Si te			
	1. 00	2.00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporti ng	
period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64. 00
in the base year period, the number of unweighted non-primary care				
resident 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)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/30/2019 3:48 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (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 0.000000 65.00 0. 00 0. 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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 P	Peri od:	u of Form CMS- Worksheet S-2	
F	from 01/01/2018 to 12/31/2018	Part I Date/Time Pre 5/30/2019 3:4	epared:
		1.00	
Long Term Care Hospital PPS 30.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	81.00
TEFRA Providers 15.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 636.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 17.00 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): Effect 1 101 yes of w 101 ho.	V	XI X	
E	1. 00	2. 00	
Title V and XIX Services OO. 00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column.			
01.00 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
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 33.00 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
04.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
applicable column. 15.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	95. 00
Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96. 00
17.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	97. 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
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
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. 18.03 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. 18.04 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. 18.05 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	N	Υ	98. 05
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 19.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	N	Υ	98. 06
column 2 for title XIX. Rural Providers			
05.00 Does this hospital qualify as a CAH? 06.00 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
07.00 f 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			107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 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 Occupati onal	Speech	Respi ratory	
1.00 2.00	3.00	4. 00	109. 00
09.00 If this hospital qualifies as a CAH or a cost provider, are N			1109.00

1.00

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A N Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0168	Peri od:		worksheet S-	
		From 01/01 To 12/31	/2018 /2018	Part I Date/Time Pr 5/30/2019 3:	
		1.00	ົ	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	st reporting period? Ento lumn 1 is Y, enter the ticipating in column 2.	er N		2.00	111.00
Ni collegeous Cost Deposting Information			1.0	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" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 is "E", ento t for long term care (ind s) based on the definition	er in column cludes	N	0	115.00
16.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insurno.	ance? Enter "Y" for yes o		N N		116.00
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. 00
	Premi ums	S Loss	es	Insurance	
	1.00	2.0		3.00	
18.01 List amounts of malpractice premiums and paid losses:	18,	836	13, 048	3	0 118. 01
		1. 00))	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.		N			118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes on alifies for the Outpatien	-		N	120.00
121.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no.	ntable devices charged to) Y			121. 00
122.00 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. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N" for no. If	N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en		te			126. 00
in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certification date	9			127. 00
128.00 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	9			128. 00
129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		in			129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col	umn 2.				130. 00
I31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	umn 2.				131. 00
32.00 If this is a Medicare certified islet transplant center, ent in column 1 and termination date, if applicable, in column 2					132.00
133.00 If this is a Medicare certified other transplant center, ent in column 1 and termination date, if applicable, in column 2 134.00 If this is an organ procurement organization (OPO), enter th		=			133.00
and termination date, if applicable, in column 2. All Providers	e or o mainiber TH COLUMN I				134.00
40.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If		Y		449008	140. 00

In Lieu of Form CMS-2552-10 Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0168 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: To 5/30/2019 3:48 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
141.00 Name: COMMUNITY HEALTH SYSTEMS Contractor's Name: WISCONSIN PHYSICIA 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 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 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 N Ν Ν N 155. 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 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. County CBSA FTE/Campus State Zip Code Name 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

reasonable cost incurred for the HII assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
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	9169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	01/01/2018	12/31/2018	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	C	171. 00
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)			

d168. 00

	Financial Systems LUTHERAN MUSCULOSE AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0168	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2018 To 12/31/2018		
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	enonege Ente	1.00	2. 00	
	mm/dd/yyyy format.	TOI AIT NO TE	sponses. Litte	all dates ill t	.ne	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N		1. 00
	reporting period. It yes, enter the date of the change in oc	7 4 4 5 6	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	fices, drug er or its the board	N			3.00
	Torut orisin ps. (see That detrois)		Y/N	Туре	Date	
	Financial Data and Reports		1. 00	2. 00	3. 00	
4. 005. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	N N			4. 00
5.00	those on the filed financial statements? If yes, submit reco		IV			3.00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		e provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		he current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. 00
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	N N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reportin	U .	yes, see inst t A	ructions. Par	N t B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Υ	05/21/2019	Y	05/21/2019	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

10SPI T	n Financial Systems LUTHERAN MUSCULOS TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0168	Peri od: From 01/01/2018	u of Form CM Worksheet S Part II	
				To 12/31/2018	Date/Time P 5/30/2019 3	
		Descri	pti on	Y/N	Y/N	. 10 piii
)	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. 0
		Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 0
	records? If yes, see instructions.					21.0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS H	OSPI TALS)			
2. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 0
3. 00			als made du	ring the cost		23. 0
24. 00	, , , , , , , , , , , , , , , , , , , ,	ed into during	this cost re	eporting period?		24. 0
5. 00		the cost repor	ting period	? If yes, see		25. 0
26. 00		ne cost reporti	ng period?	If yes, see		26. 0
7. 00		cost reportin	g period? I	f yes, submit		27. 0
8. 00	Interest Expense	itered into dur	ing the cos	t reporting		28. 0
9. 00			bt Service I	Reserve Fund)		29. 0
0. 00		ructions urity with new	debt? If yes	s, see		30.0
1. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see		31. 0
2. 00	Purchased Services	vices furnishe	d through co	ontractual		32.0
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	ıcti ons.	-			33. 0
	no, see instructions. Provider-Based Physicians					
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	ased physicians?		34.0
5. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. C
	The cost reporting period: IT yes, see IT	istractions.		Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?					36.0
7. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office	?		37. 0
8. 00				f		38. C
9. 00				s,		39. C
0. 00		home office?	If yes, see			40. C
		1	00	2.	<u></u>	
	Cost Report Preparer Contact Information	1.				
		STEVEN		BAUER		41. 0
1. 00						
1. 00	respecti vel y.	COMMUNITY HEAL	TH SYSTEMS			42.0

552-10
ared:
pm
41. 00
42. 00
43.00

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:
 Heal th Financial
 Systems
 LUTHERAN M

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0168

				Т	o 12/31/2018	Date/Time Prep 5/30/2019 3:48	
						I/P Days / 0/P	5 PIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number	0. 5000	Avai I abl e	0, 11, 11,0 41, 0		
		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
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		39	14, 235	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	C	1			8. 00
9. 00	CORONARY CARE UNIT	32. 00	C	1			9. 00
10. 00	BURN INTENSIVE CARE UNIT	33. 00	C	1			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	C	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00	0.0			0	13.00
14.00	Total (see instructions)		39	14, 235	0.00		14.00
15. 00	CAH visits	40.00				0	15. 00
16.00	SUBPROVI DER - I PF	40.00	C			0	16. 00
17. 00	SUBPROVIDER - I RF	41. 00	C	0		0	17. 00
18. 00 19. 00	SUBPROVI DER	44. 00	C			0	18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44. 00 45. 00	(0	20. 00
21. 00	OTHER LONG TERM CARE	46. 00	(ή		U	21. 00
22. 00	HOME HEALTH AGENCY	101. 00	C	'l		0	21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23. 00
24. 00	HOSPICE	116. 00	(24. 00
24. 10	HOSPICE (non-distinct part)	30. 00		ή			24. 10
25. 00	CMHC - CMHC	99. 00				0	25. 00
25. 10	CMHC - CORF	99. 10				Ö	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	39			Ŭ	27. 00
28. 00	Observation Bed Days		0.			0	28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		C	ol o)		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-0168

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm

						5/30/2019 3:4	8 pm
		I/P Days	6 / 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	1, 811	31	5, 424			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	4 000	0.40				0.00
2.00	HMO and other (see instructions)	1, 303	342				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	l ~			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	1 011	0	0 5, 424			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 811	31	5, 424			7. 00
8. 00	INTENSIVE CARE UNIT	0	0	C			8. 00
9. 00	CORONARY CARE UNIT		0				9.00
10. 00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	l	O				12.00
13. 00	NURSERY		0	ر ا			13.00
14. 00	Total (see instructions)	1, 811	31	5, 424	0.00	239. 40	14.00
15. 00	CAH visits	1,011	0		0.00	237. 40	15. 00
16. 00	SUBPROVIDER - I PF	l o	0	1	0.00	0.00	16.00
17. 00	SUBPROVI DER - I RF	l ol	0	1			
18. 00	SUBPROVI DER		_				18. 00
19. 00	SKILLED NURSING FACILITY	l ol	0	l c	0.00	0.00	19. 00
20. 00	NURSING FACILITY		0	C			
21. 00	OTHER LONG TERM CARE			C		l e	21.00
22. 00	HOME HEALTH AGENCY	o	0	C	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	o	0	l c	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25.00	CMHC - CMHC	0	0	C	0.00	0.00	25. 00
25. 10	CMHC - CORF	O	0	C	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	0	C			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	239. 40	27. 00
28. 00	Observation Bed Days		0	558			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provider CCN: 15-0168

				To	12/31/2018	Date/Time Pre 5/30/2019 3:4	
		Full Time		Di sch	arges	070072017 011	J
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	12.00	14.00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12. 00	13. 00	14.00	2, 392	1, 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		O	724	5	2, 392	1.00
2.00	HMO and other (see instructions)			538	136		2.00
3.00	HMO IPF Subprovider				ol		3. 00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	724	5	2, 392	14.00
15.00	CAH visits					·	15. 00
16.00	SUBPROVIDER - IPF	0. 00	0	0	o	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	ol	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	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0168

Minch Minch A Line Reported Report						T	o 12/31/2018	Date/Time Prep	
SATE 1. MIGE DATA 1.00 2.00 3.00 4.00 5.00 6.00					on of Salaries	Sal ari es	Related to	Average Hourly Wage (col. 4 ÷	5 pili
MARTIE SAFANETS						`		col. 5)	
Name Contract Co		DART II - WACE DATA	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
2. District toms)		SALARI ES							
2.00	1. 00		200. 00	15, 061, 962	0	15, 061, 962	497, 947. 00	30. 25	1. 00
4. 00 Physician-Part A -	2.00			0	О	0	0.00	0. 00	2. 00
4. Administrative with Physicians Part A - Teaching	3. 00	Non-physician anesthetist Part		0	0	О	0.00	0. 00	3. 00
4.01 Physicians - Part A - Teaching 0 0 0 0 0 0 0 0 0	4.00	B Physician-Part A -		0	0	0	0. 00	0.00	4. 00
Physician and Non	4. 01			O	0	0	0. 00	0. 00	4. 01
5.00 Non-physic an Part 8 for non-physic no	5. 00	Physician and Non		0	0	0	0.00	0.00	5. 00
7. 00 Interms & residents (in an approved program) 0.00 0.0	6.00	Non-physician-Part B for		0	0	0	0. 00	0. 00	6. 00
7. of Contracted interns and residents (in an approved program) 8. 00 0 0 0 0 0 0 0 0 0	7.00	servi ces	21.00	0			0.00	0.00	7.00
Roof of the control		approved program)	21.00	U	0	U			
Nome office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0	7. 01	residents (in an approved		0	0	0	0. 00	0.00	7. 01
SNF	8. 00			0	0	0	0. 00	0. 00	8. 00
10.00 Excluded area salaries (see 1,642,857 0 1,642,857 64,175,00 25.60 10.00	9. 00		44. 00	0	0	0	0. 00	0.00	9. 00
OTHER WAGES & RELATED COSTS 11.00 CONTRACT Labors: Direct Patient 79,772 0 79,772 2,427.00 32,87 11.00 Contract Labor: Top Level 0 0 0 0 0.00 0.00 12.00 1		1		1, 642, 857	0	1, 642, 857			
Care		OTHER WAGES & RELATED COSTS							
management and other management and other management and odministrative services	11. 00			79, 772	0	79, 772	2, 427. 00	32. 87	11. 00
nanagement and admin is trait ve services 13.00 Contract labor; Physician-Part 19,163 0 19,163 102.00 187.87 13.00 14.00 organization salaries and wage-related costs 14.01 Home office and/or related organization salaries and wage-related costs 2,003,805 0 2,003,805 72,341.00 27.70 14.01 14.00 0 0 0 0 0 0 0 0 0	12. 00	· · · · · · · · · · · · · · · · · · ·		0	0	0	0. 00	0. 00	12. 00
13.00 Contract labor: Physician-Part 19,163 0 19,163 102.00 187.87 13.00 14.00 14.00 14.00 14.00 16.00 14.		management and administrative							
14.00	13. 00	Contract Labor: Physician-Part		19, 163	0	19, 163	102. 00	187. 87	13. 00
14. 01 Home office salaries 2,003,805 0 2,003,805 72,341.00 27. 70 14. 01 14. 02 Related organization salaries 0 0 0 0 0.00 0.00 15. 00 Home office: Physician Part A 0 0 0 0 0.00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 16. 00 Home office: Physician Part A 0 0 0 0 0.00 17. 00 Home office: Physician Part A 0 0 0 0 18. 00 Home office: Physician Part A 0 0 0 0 19. 00 Physician Part A 0 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00 0 0 10. 00	14. 00	Home office and/or related organization salaries and		0	О	0	0.00	0. 00	14. 00
14. 02 Related organization salaries 0 0 0 0.00 0.00 14. 02	14. 01			2, 003, 805	0	2, 003, 805	72, 341. 00	27. 70	14. 01
16.00 Home office and Contract Home office				0	0	_			
Physicians Part A - Teaching		- Administrative		0	0				
17.00 Wage-rel ated costs (core) (see instructions) 167,100 167,100 167,100 18.00 18.00 Wage-rel ated costs (other) 167,100 0 167,100 18.00 19.00 Excluded areas 434,734 0 434,734 19.00 20.00 Non-physician anesthetist Part	16.00	Physicians Part A - Teaching			0	0	0.00	0.00	16.00
18. 00 Wage-related costs (other) 167, 100 0 167, 100 18. 00 19. 00 Excl uded areas 434, 734 0 434, 734 19. 00 20. 00 Non-physic ian anesthetist Part 0 0 0 0 10. 00 Non-physic ian anesthetist Part 0 0 0 0 10. 00 Non-physic ian anesthetist Part 0 0 0 0 10. 00 Non-physic ian anesthetist Part 0 0 0 0 10. 00 Non-physic ian anesthetist Part 0 0 0 0 10. 00 Non-physic ian Part A - Administrative 0 0 0 0 10. 00 Physic ian Part A - Teaching 0 0 0 0 10. 00 Non-physic ian Part B 0 0 0 0 10. 00 Non-physic ian Part B 0 0 0 0 10. 00 Non-physic ian Part B 0 0 0 10. 00 Non-physic ian Part A - Non-physic ian Part B 0 0 0 10. 00 Non-physic ian Part A - Non-physic ian Part B 0 0 0 10. 00 Non-physic ian Part A - Non-physic ian Part B 0 0 0 10. 00 Non-physic ian Part A - Non-physic ian Part A - Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 0 0 0 10. 00 Non-physic ian Part A 0 0 0 0 10. 00 Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 0 0 10. 00 Non-physic ian Part A 0 10. 0	17. 00			3. 027. 228	I 0	3, 027, 228			17. 00
See instructions Sec Ins		instructions)							
20. 00 Non-physician anesthetist Part A Non-physician anesthetist Part B 21. 00 Non-physician Part A A Administrative Physician Part A - Teaching District One Physician Part B A District One Physician Part B A District One Physician Part B District One Physician Part B District One Physician Part B District One Dist		(see instructions)							
B		1		434, 734 0	0	434, 734 0			
Administrative	21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 01 Physician Part A - Teaching 0 0 0 0 22. 01	22. 00			0	0	0			22. 00
23. 00	22 01	1		0	0	0			22 01
25. 00 Interns & residents (in an approved program) 25. 00 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A 0 0 0 0 25. 52 25. 53 Home office & Contract 0 0 0 0 0 25. 53 Physicians Part A - Teaching - wage-related (core) 25. 53 Physicians Part A - Teaching - wage-related (core) 25. 53 Physicians Part A - Teaching - wage-related (core) 25. 53 25. 54 25. 55 25. 5				0	Ö	Ö			
25. 50 August A				0	0	0			
Core Core Related organization Core Core Related organization Core Cor		approved program)		403 061	0	403 061			
wage-related (core)		(core)		,					
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department		wage-related (core)		0					
25. 53 Home office & Contract	∠ט. 5∠	- Administrative -		U					∠ט. 5∠
wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4.00 0 0 0 0.00 26.00	25. 53	Home office & Contract		0	0	0			25. 53
26. 00 Employee Benefits Department 4. 00 0 0 0 0 0. 00 26. 00		wage-related (core)							
	26 00			0	0	0	0.00	0.00	26 00

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

							5/30/2019 3: 4	8 pm
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d 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	0	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	55, 356	0	55, 356	1, 804. 00	30. 69	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	0	0.00		32. 00
33.00	Housekeeping under contract		390, 865	0	390, 865	23, 867. 00	16. 38	33. 00
	(see instructions)							
34.00	Di etary	10. 00	C	0	0	0.00	0. 00	34.00
35.00	Di etary under contract (see		38, 823	0	38, 823	4, 102. 00	9. 46	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	C	0	0	0.00	0. 00	36. 00
37.00	Maintenance of Personnel	12. 00	C	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	228, 848	166, 059	394, 907	8, 761. 00	45. 08	38. 00
39. 00	Central Services and Supply	14. 00	481, 410	0	481, 410	26, 021. 00	18. 50	39. 00
40.00	Pharmacy	15. 00	C	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	12, 154	0	12, 154	539.00	22. 55	41.00
	Records Library							
42.00	Social Service	17. 00	C	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	C	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part | Provider CCN: 15-0168

					'	0 12/01/2010	5/30/2019 3: 4	
		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 ± 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		15, 491, 650	0	15, 491, 650	525, 916. 00	29. 46	1. 00
	instructions)							
2.00	Excluded area salaries (see		1, 642, 857	0	1, 642, 857	64, 175. 00	25. 60	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		13, 848, 793	0	13, 848, 793	461, 741. 00	29. 99	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		2, 102, 740	0	2, 102, 740	74, 870. 00	28. 09	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		3, 597, 389	0	3, 597, 389	0. 00	25. 98	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		19, 548, 922	0	19, 548, 922	536, 611. 00	36. 43	6. 00
7.00	Total overhead cost (see		3, 806, 126	0	3, 806, 126	141, 511. 00	26. 90	7. 00
	instructions)							

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0168		Worksheet S-3
		From 01/01/2018	
		To 12/21/2019	Data/Tima Dranarad

	To 12/31/2018	Date/Time Prep 5/30/2019 3:48	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	293, 432	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	1, 993, 655	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	10, 605	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10, 684	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	-84	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	2, 171	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	92, 908	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	825, 731	17. 00
18.00	Medicare Taxes - Employers Portion Only	193, 115	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	39, 744	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0	1 20.00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	3, 461, 961	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	167, 100	25. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0168	Peri od:	Worksheet S-3
		From 01/01/2018	Part V

		To	12/31/2018	Date/Time Prep 5/30/2019 3:48	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		79, 772	3, 461, 961	1. 00
2.00	Hospi tal		79, 772	3, 461, 961	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
13. 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
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

Medicaid (see instructions for each line)	Heal th	Financial Systems LUTHERAN MUSCULOSKELE	TAL CENTER	In Lie	u of Form CMS-2	2552-10
Incompensated and Indigent care cost computation 1.00	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0168		Worksheet S-1	0
Uncompensated and Indigent care cost computation 1.00					Date/Time Pre	nared:
Uncompensated and Indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 2.01 Note to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 2.02 Column 8) 2.03 In line 3 (see Instructions for each line) 3.04 Jif line 3 (see Instructions for each line) 3.06 Did you receive DSH or supplemental payments from Medicaid? 4.07 If line 3 (soe See Iline 2 Include all DSH and/or supplemental payments from Medicaid? 4.08 If line 3 (soe See Iline 2 Include all DSH and/or supplemental payments from Medicaid? 5.09 If line 4 (soe See Iline 2 Include all DSH and/or supplemental payments from Medicaid? 6.00 Medicaid charges 6.00 Medicaid charges 7.00 Medicaid charges 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if care of then enter zero) 9.00 Net revenue from Stand-alone CHIP (see Instructions for each line) 8.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) 9.01 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) 9.0 Other state or local government indigent care program (see Instructions for each line) 10.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) 10.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 10.00 State or local indigent care program cost (line 1 times line 14) 10.00 Charges for patients covered under state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) 10.00 Charges for patients covered under state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) 10.00 Charges for patients donations or transfers for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 10.00 Charges for pati				10 12/01/2010		
Cost to charge ratio (Worksheet C, Part Tine 202 column 3 divided by line 202 column 8) Column 1					1. 00	
Modicaid (see instructions for each line)						
2.00 Net revenue From Medicaid 3.00 Did you receive DSH or supplemental payments from Medicaid? 4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 4.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? 4.00 Medicaid charges 7.00 Medicaid cost (line 1 times line 6) 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 7.00 Children's Heal th Insurance Program (CHIP) (see instructions for each line) 9.00 Net revenue from stand-al one CHIP (see instructions for each line) 9.00 Stand-al one CHIP cost (line 1 times line 10) 9.01 OS Stand-al one CHIP cost (line 1 times line 10) 9.02 Obther state or local government indigent care program (see instructions for each line) 9.03 Net revenue from state or local indigent care program (see instructions for each line) 9.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 9.01 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 9.02 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 9.01 State or local indigent care program cost (line 1 times line 14) 9.02 State or local indigent care program cost (line 1 times line 14) 9.03 State or local indigent care program cost (line 1 times line 14) 9.04 Obther state or local indigent care program (Not included in lines 6 or 10) 9.05 State or local indigent care program cost (line 1 times line 14) 9.06 Obther state or local indigent care program (Not included in lines 6 or 10) 9.07 State or local indigent care program cost (line 1 times line 14) 9.08 State or local indigent care program cost (line 1 times line 14) 9.09 Total cost of patients overed under state or local indigent care program (line 15 minus line 24, 733 list if x zero then enter zero) 9.00 Cost of care then enter zero) 9.00 Cost of patients donations, or endowment income restricted to funding charity care 9.00 Cost of patients	1. 00	· ·	ided by line 202 colu	ımn 8)	0. 112916	1.00
1	2.00				4, 084, 198	2. 00
1 1 1 1 1 1 1 1 1 1	3.00				Υ	3. 00
Medicald charges 31,025,022 3,503,221 3,503,22		1		cai d?		4. 00
Action Medical dot cost (line 1 times line 6) 3,503,221 8.00 Difference between net revenue and costs for Medicald program (line 7 minus sum of lines 2 and 5; if		1	om Medicaid		_	
Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2 zero then enter zero)						
czero then enter zero)		•	line 7 minus sum of L	ines 2 and 5: if		1
9.00 Net revenue from stand-al one CHIP 10.00 Stand-al one CHIP charges 11.00 Stand-al one CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9: if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Covernment grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients patients + col. 2) 1.00 Cost of patients patients - col. 2) 1.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 2, 218, 200 2, 200 Payments received from patients for amounts previously written off as 0 0 0 0 2, 200 Cost of charity care (line 21 minus line 22) 23.00 Cost of charity care (line 21 minus line 22) 252, 797 2		< zero then enter zero)				
10.00 Stand-alone CHIP cost (line 1 times line 10) 11.00 Stand-alone CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Covernment grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 19.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 2 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 (see instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 charity care 23.00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2			r each line)			
11.00 Stand-alone CHIP cost (line 1 times line 10) 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					-	
Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 469, 360 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2		į				
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 28, 265 1 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 1 1 if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 1 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ling 11 minus ling 0:	if / zero then		1
Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients Insured patients 1 houred patients 1 patients 1 houred patients 1 patients 1 houred patients 1 houred patients 20, 200 3.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 2 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	12.00		illie il illilius illie 4,	II < Zero then	0	12.00
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 8, 12 and 16) 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 8, 12 and 16) 19.00 Charity care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 2 charity care 23.00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2		· · · · · · · · · · · · · · · · · · ·	ructions for each lir	ie)		
15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) Private grants, donations, or endowment income restricted to funding charity care 0 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients patients 1 + col. 2) 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22. 00 Payments received from patients for amounts previously written off as 0 0 0 0 2 charity care 23. 00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2 250, 174 2, 623 250, 174 2, 623 250, 174						
15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 24, 733 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients patients patients patients patients patients 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 2 charity care 23.00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2 250, 797 2	14. 00		program (Not include	ed in lines 6 or	469, 360	14. 00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients patients patients patients 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2, 215, 577 2, 623 2, 218, 200 2 (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 0 charity care 23.00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2	15 00	,	`		E2 000	15 00
13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 18, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 250, 174 2, 623 252, 797 2 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2, 623 252, 797 2 2 250, 174 2 2, 623 252,				ine 15 minus line		
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 24, 733 8, 12 and 16) Uninsured patients Total (col. 1 patients + col. 2 1.00 2.00 3.00 Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line)	10.00		rgent care program (r	THE 13 IIITIUS TITLE	24, 733	10.00
17.00 Private grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 19.00 24,733 24,			P and state/local inc	ligent care progran	ns (see	
19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Total (col. 1 + col. 2) 1.00 2.00 3.00 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 (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Dividually and 10 indigent care programs (sum of lines 24, 733 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	17. 00		nding charity care		0	17. 00
8, 12 and 16) Uninsured patients Insured patients Total (col. 1 + col. 2)	18. 00				_	18. 00
Uncompensated Care (see instructions for each line) 20. 00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) Uninsured patients Insured patients Total (col. 1 + col. 2) 2 (20. 0) 2 (215, 577) 2, 623 2, 218, 200 2 (215, 577) 2, 623 2, 218, 200 2 (215, 577) 2, 623 2, 218, 200 2 (216, 207) 2, 623 2, 218, 200 2 (217, 207) 2, 623 2, 218, 200 2 (218, 200) 2, 623	19. 00		indigent care progra	ms (sum of lines	24, 733	19. 00
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 250, 174 Cost of charity care (line 21 minus line 22) 250, 174 Cost of charity care (line 21 minus line 22) 250, 174 Cost of charity care (line 21 minus line 22)			Uni nsure	d Insured		
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 250,174 2,623 2,218,200 2,623 2,218,200 2,623 2,218,200 2,623 2,218,200 2,623 2,218,200 2,623 2,623 2,218,200 2,623 2,623 2,218,200 2,623 2,623 2,218,200 2,623 2,623 2,218,200 2,623 2,623 2,797 2,623 2,623 2,797 2,623 2,797 2,623 2,797 2,623						
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 2, 218, 200 2 250, 174 2, 623 2, 218, 200 2 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2		Uncomponented Caro (see instructions for each Line)	1.00	2.00	3.00	
(see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2 250, 174 2, 623 252, 797 2 250, 174	20. 00		ility 2, 215.	577 2, 623	2, 218, 200	20.00
instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 250,174 2,623 252,797 2			_,_,,	-,	_,,	
22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 250,174 2,623 252,797	21. 00		nts (see 250,	174 2, 623	252, 797	21. 00
Charity care	00.00	·	66			00.00
23. 00 Cost of charity care (line 21 minus line 22) 250, 174 2, 623 252, 797 2	22.00		orr as	0	0	22. 00
	23. 00		250.	174 2, 623	252, 797	23. 00
1 00		,		-7.7	===,	
					1. 00	
	24. 00			h of stay limit	N	24. 00
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0 2	25. 00			ram's length of	0	25. 00
stay limit	0, 00	1 3			4 740 4	0, 05
26.00 Total bad debt expense for the entire hospital complex (see instructions) 1,713,450 2			,			
		· · ·	•			
			ce mistructions)			1
			ense (see instruction	ıs)		1
=		!	(•		1
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 468,880 3		Total unreimbursed and uncompensated care cost (line 19 plus li				

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (Cost Center Description	Sal ari es	Provider CC Other	F	Period: From 01/01/2018 To 12/31/2018 Reclassificati	Worksheet A Date/Time Pre 5/30/2019 3:4 Reclassified	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati		
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		204, 920	204, 920		5, 138, 832	1.00
2.00	OO200 CAP REL COSTS-MVBLE EQUIP OO300 OTHER CAP REL COSTS		1, 289, 855	1, 289, 855		1, 548, 507	2.00
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	107, 985	107, 985	ή	0 2, 651, 934	3. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 598, 670	32, 366, 638	34, 965, 308		29, 069, 055	5. 00
7.00	00700 OPERATION OF PLANT	55, 356	1, 098, 879	1, 154, 235	482, 012	1, 636, 247	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	120, 721	120, 721		120, 721	
9.00	00900 HOUSEKEEPI NG	0	458, 772	458, 772		456, 312	
10. 00 12. 00	01000 DIETARY 01200 MAINTENANCE OF PERSONNEL	0	261, 782	261, 782 (1	262, 488 0	10. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	228, 848	552, 306	781, 154	1	947, 154	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	481, 410	13, 868, 483			945, 889	
15. 00	01500 PHARMACY	0	1, 894, 213	1, 894, 213	-1, 304, 382	589, 831	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	12, 154	748, 338	760, 492	-4, 671	755, 821	
	01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CES	0	0			0	17.00
	01900 NONPHYSICIAN ANESTHETISTS		0			0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL		Ö		ol ol	0	20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	C	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0) 0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 238, 382	499, 768	2, 738, 150	-79	2, 738, 071	30.00
	03100 INTENSIVE CARE UNIT	2, 230, 302	477, 700	2, 730, 130	0	2, 730, 071	31.00
32. 00	03200 CORONARY CARE UNIT	Ö	0	C	o	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	o	0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0			0	40.00
41. 00 43. 00	04300 NURSERY		0			0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY		0		ol ol	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	C	o	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	2 000 20/	0.01/.0/2	12, 906, 169	1 405 027	11 120 222	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	3, 889, 206 1, 332, 320	9, 016, 963 482, 140		,	11, 420, 332 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 332, 320	402, 140	1, 014, 400		0	52.00
53. 00	05300 ANESTHESI OLOGY	Ö	43, 579	43, 579	-43, 579	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	190, 584	337, 376			445, 178	
	03630 ULTRA SOUND	0	5, 107	5, 107	0	5, 107	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			0	
	05700 CT SCAN		5, 6 58	5, 658		5, 658	
58. 00	05800 MRI	440	1, 623	2, 063		2, 063	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	o	0	59. 00
60.00	06000 LABORATORY	3, 067	460, 285	463, 352	-3, 823	459, 529	
	06001 BLOOD LABORATORY	0	0		0	0	60. 01 61. 00
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0			0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		ol ol	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	18, 688			18, 688	
66.00	06600 PHYSI CAL THERAPY	2, 024, 878	825, 607	2, 850, 485		2, 691, 410	
67.00	06700 OCCUPATIONAL THERAPY	363, 410 380	26, 809 67			0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	300	67 23, 619	447 23, 619		23, 619	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY		20, 017	25, 517	ol ől	23, 017	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1, 464, 196		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		13, 588, 504	13, 588, 504	
	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 157, 476	1, 157, 476	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	O O			0	74. 00 75. 00
, 5. 50	OUTPATIENT SERVICE COST CENTERS	<u>, </u>	0		٠, ٥	0	1 . 5. 66
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
	09000 CLI NI C	0	0			0	
90.00	O9100 EMERGENCY	1 O	0	(ار ا	0	
90. 00 91. 00							1 (3') (1(1)
90. 00 91. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
90. 00 91. 00 92. 00		0	0		0 0	0	

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER		In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS (TRIAL BALANCE OF EXPENSES	Provider CCN: 15-0168	Peri od:	Worksheet A

Health Financial Systems LU	THERAN MUSCULOSK	ELETAL CENTER		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/30/2019 3:4	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cati		<u>р</u>
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	70.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0		0	0	98. 00
99. 00 09900 CMHC	0	0		0	0	99. 00
99. 10 09910 CORF	0	0		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS					T -	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106. 00 10600 HEART ACQUISITION	0	0		0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0		0		111.00
113. 00 11300 INTEREST EXPENSE		0		0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00 116. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 419, 105	64, 720, 181	78, 139, 28	3, 336		
NONREI MBURSABLE COST CENTERS	13, 417, 103	04, 720, 101	70, 137, 20	3, 330	70, 142, 022	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH		0				191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	826	16, 194	17, 02	.0 -1, 996		192. 00
193. 00 19300 NONPALD WORKERS	020	10, 171	17,02	0 1,770		193. 00
194. 00 07950 SPORTS MEDICINE	1, 642, 031	522, 401	2, 164, 43	-1, 340		
194. 01 07951 SENI OR CI RCLE	0	022, 101	2, , 10	0 .,010		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	15, 061, 962	65, 258, 776	80, 320, 73	0	80, 320, 738	

Provider CCN: 15-0168

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/30/2019 3:48 pm

			5/30/2019 3: 4	8 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				1
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-2, 621, 697		•	1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P	-33, 218		1	2. 00
3. 00 00300 OTHER CAP REL COSTS	0		l .	3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0		•	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-17, 914, 777	11, 154, 278		5. 00
7. 00 00700 OPERATION OF PLANT	-8, 416			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0			8. 00
9. 00 00900 HOUSEKEEPI NG	0		1	9.00
10. 00 01000 DI ETARY	0			10.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	1	l .	12.00
13. 00 01300 NURSING ADMINISTRATION	0		1	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0			14.00
15. 00 01500 PHARMACY	0			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0			16.00
17. 00 01700 SOCIAL SERVICE	0	0	l control of the cont	17. 00
18. 00 01850 OTHER GENERAL SERVICES	0	0		18.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		19.00
20. 00 02000 NURSI NG SCHOOL	0	1		20.00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRV	0	1		21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0		l .	22. 00
23. 00 O2300 PARAMED ED PRGM	0	0		23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 720 071		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	l e	·	31.00
32. 00 03200 CORONARY CARE UNIT	0	l e		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	1		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0			34.00
40. 00 04000 SUBPROVI DER - I PF	0	0		40.00
41. 00 04100 SUBPROVI DER - RF	0	0		41.00
43. 00 04300 NURSERY	0	0		43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0		44. 00
45. 00 04500 NURSING FACILITY	0		l .	45. 00
46. 00 O4600 OTHER LONG TERM CARE	0	0		46. 00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	11, 420, 332		50.00
				1
51. 00 05100 RECOVERY ROOM	0		l control of the cont	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		1		52.00
				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0			54. 00 54. 01
54. 01 03630 ULTRA SOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	5, 107 0	l .	55. 00
56. 00 05600 RADI 0LOGY - THERAPEUTI C	0		·	56.00
57. 00 05700 CT SCAN		1	l .	57.00
58. 00 05800 MRI			•	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			l .	59.00
60. 00 06000 LABORATORY		1	1	60.00
60. 01 06001 BLOOD LABORATORY			•	60.00
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY				61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.				63.00
64. 00 06400 NTRAVENOUS THERAPY				64. 00
65. 00 06500 RESPI RATORY THERAPY	0	18, 688		65. 00
66. 00 06600 PHYSI CAL THERAPY	-805			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-805	2,090,005		67.00
68.00 06800 SPEECH PATHOLOGY				68.00
69. 00 06900 SPEECH PATHOLOGY		23, 619		69.00
70. 00 07000 ELECTROCARDI OLOGY		23,019		70.00
71. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		1, 464, 196		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		•	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		•	73. 00
74. 00 07400 RENAL DI ALYSI S				74.00
75. 00 07500 ASC (NON-DISTINCT PART)				75.00
OUTPATIENT SERVICE COST CENTERS			1	1 ,3.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				90.00
	0			90.00
· · · · · · · · · · · · · · · · · · ·				1
		l		92.00
94. 00 O7HER REIMBURSABLE COST CENTERS 94. 00 O9400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES			1	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			1	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED		ł .	•	97.00
35 JON 99 POWERE MEDI ONE EQUIT-SOLD	1 0	1 0	1	1 ,,,,,,,,

| Peri od: | Worksheet A | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0168

				e/lime Prepared: 0/2019 3:48 pm
Cost Center Description	Adjustments	Net Expenses	1 0, 0,	57 2017 G. 10 pin
· ·		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 ACQUI SI TI ON	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-20, 578, 913	57, 563, 709		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	15, 024		192. 00
193.00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	-7, 349	2, 155, 743		194. 00
194. 01 07951 SENI OR CI RCLE	0	0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-20, 586, 262	59, 734, 476		200. 00

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 3: 48 pm

					To 12/31	/2018 Date/Time Prepared: 5/30/2019 3:48 pm
		Increases				1 67 667 26 7 7 6 7 6 7 11
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00		2, 543, 949		1.00
	D DENITAL AND LEASE		0	2, 543, 949		
1. 00	B - RENTAL AND LEASE CAP REL COSTS-BLDG & FIXT	1.00	0	4, 391, 362		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	2.00	0	252, 002		2.00
3. 00	CAI REE COSTS-WVDEE EQUIT	0.00	0	232, 002		3.00
4. 00		0.00	0	Ö		4.00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	o	0		7. 00
		+		4, 643, 364		
	C - OTHER CAPITAL COST					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	82, 320		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	460, 230		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>6, 6</u> 50		3. 00
	0		0	549, 200		
	D - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7. 00	0	482, 012		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	O O	0		11.00
12. 00 13. 00	1	0. 00 0. 00	0	0		12.00
13.00				0 482, 012		13. 00
	E - CHIEF NURSING OFFICER		<u> </u>	402, 012		
1.00	NURSI NG ADMI NI STRATI ON	13. 00	166, 059	0		1. 00
	0		166, 059	0		1
	F - MEDICAL SUPPLIES			<u> </u>		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 464, 196		1.00
	PATI ENT					
2.00	I MPL. DEV. CHARGED TO	72. 00	0	13, 588, 504		2.00
	PATIENTS		_			
	ADMINISTRATIVE & GENERAL	5. 00	0	41		3.00
	DI ETARY	10.00	0	706		4.00
	ADULTS & PEDIATRICS	30.00	0	1, 676		5. 00
	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 192		6.00
7. 00	PHYSICAL THERAPY	6600		<u>1, 465</u> 15, 059, 780		7. 00
	G - DRUGS/IV SOLUTIONS		<u> </u>	15, 059, 760		
1. 00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 157, 476		1.00
1.00	0		 	1, 157, 476		1.00
	H - MISC DEPTS		٥	,, , , , , , ,		
1.00	PHYSI CAL THERAPY	66.00	363, 790	26, 876		1.00
2. 00		0.00	0	0		2. 00
- =			363, 790	26, 876		2.33
	I - OTHER					
1.00	OPERATING ROOM	50.00	1, 332, 320	522, 293		1. 00
	1					
2.00		0.00	0			2. 00
		0.00	00 1, 332, 320	00522, 293		2.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0168

					10	5/30/2019	
		Decreases		<u>'</u>		, , , , , , , , , , , , , , , , , , , ,	
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL		0	2, 543, 949	0		1. 00
	0		0	2, 543, 949			
	B - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2, 423, 938	10		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	59, 944	10		2. 00
3.00	PHARMACY	15. 00	0	104, 054	0		3. 00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	4, 671	0		4. 00
5.00	OPERATING ROOM	50.00	0	1, 424, 819	0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	81, 379	0		6. 00
7.00	PHYSI CAL THERAPY	66.00	o	544, 559	o		7. 00
				4, 643, 364			1
	C - OTHER CAPITAL COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	549, 200	12		1.00
2.00		0.00	o				2. 00
3.00		0.00	o	C	12		3. 00
				549, 200			1
	D - REPAIRS & MAINTENANCE		<u> </u>	0.77200			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	213, 148	0		1.00
2. 00	HOUSEKEEPI NG	9. 00	0	2, 460			2. 00
3. 00	NURSI NG ADMINI STRATI ON	13. 00	0	59			3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	45, 931			4. 00
5. 00	PHARMACY	15. 00	o o	42, 852			5. 00
6. 00	ADULTS & PEDIATRICS	30.00	0	1, 755	1		6. 00
7. 00	OPERATING ROOM	50.00	0	154, 731	1		7. 00
8. 00	RECOVERY ROOM	51. 00	0	2, 675	1		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 675 4, 595			9. 00
10. 00	LABORATORY	60.00	0				10.00
	PHYSI CAL THERAPY	•	0	3, 823	1		11. 00
11.00		66.00	U	6, 647			4
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 996	1		12.00
13. 00	SPORTS MEDICINE	1 <u>94.</u> 00		1, 340			13. 00
	U		0	482, 012			
4 00	E - CHIEF NURSING OFFICER	F 00	4// 050				4 00
1.00	ADMI NI STRATI VE & GENERAL		16 <u>6, 0</u> 59	<u> </u>	0		1. 00
	0		166, 059	C)		
	F - MEDI CAL SUPPLI ES	44.00		10 000 100	J		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	13, 298, 129			1.00
2.00	OPERATI NG ROOM	50.00	0	1, 760, 900			2. 00
3. 00	RECOVERY ROOM	51. 00	0	751	1		3. 00
4.00		0.00	O	C	1		4. 00
5. 00		0. 00	0	C	1 -1		5. 00
6.00		0. 00	0	C	1 1		6. 00
7. 00		0.00			0		7. 00
	0		0	15, 059, 780			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	1500	0_	<u>1, 157, 4</u> 76	<u> </u>		1. 00
	0		0	1, 157, 476			
	H - MISC DEPTS				,		
1.00	OCCUPATI ONAL THERAPY	67. 00	363, 410	26, 809			1. 00
2.00	SPEECH PATHOLOGY		380	67			2. 00
	0		363, 790	26, 876			
	I - OTHER						
1.00	RECOVERY ROOM	51.00	1, 332, 320	478, 714	0		1.00
2.00	ANESTHESI OLOGY	53.00	O	43, 579			2. 00
		+	1, 332, 320	522, 293			1
500.00	Grand Total: Decreases		1, 862, 169	24, 984, 950			500.00
							,

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0168

					Γο 12/31/2018		
				Acqui si ti ons		3/30/2019 3.4	o piii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	0	0	(0	0	1. 00
2.00	Land Improvements	26, 765	0	(0	0	2. 00
3.00	Buildings and Fixtures	454, 834	52, 963	(52, 963	0	3. 00
4.00	Building Improvements	4, 330, 019	2, 557, 563	(2, 557, 563	0	4. 00
5.00	Fi xed Equi pment	428, 511	236, 421	(236, 421	0	5. 00
6.00	Movable Equipment	11, 308, 840	4, 453, 717	(4, 453, 717	1, 257, 055	6. 00
7. 00	HIT designated Assets	202, 081	0	(0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	16, 751, 050	7, 300, 664	(7, 300, 664	1, 257, 055	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	16, 751, 050	7, 300, 664		7, 300, 664	1, 257, 055	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYGIC OF GUANGES IN GARLEAL ACCE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					4 00
1.00	Land	0 7.5	0				1.00
2.00	Land Improvements	26, 765	0				2.00
3.00	Buildings and Fixtures	507, 797	U				3. 00
4.00	Building Improvements	6, 887, 582	U				4. 00
5.00	Fixed Equipment	664, 932	U				5. 00
6. 00 7. 00	Movable Equipment	14, 505, 502 202, 081	0				6. 00 7. 00
7. 00 8. 00	HIT designated Assets		0				8.00
9. 00	Subtotal (sum of lines 1-7) Reconciling Items	22, 794, 659	0				9.00
10, 00	Total (line 8 minus line 9)	22, 794, 659	0				10.00
10.00	Tiotal (Title 6 millus Title 9)	22, 194, 039	υĮ				10.00

Heal th	Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER)	In lie	u of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS	THEIRIN MOSCOLOS	Provi der CO		Peri od:	Worksheet A-7	
	or Erritton of our time doors delitelie		1		From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/30/2019 3:4	8 pm
			SL	JMMARY OF CAP	PITAL		
	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 WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	204, 920	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 289, 855	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 494, 775	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	204, 920				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 289, 855				2. 00
3 00	Total (sum of lines 1-2)	ا ما	1 494 775				3 00

0 0 0

204, 920 1, 289, 855 1, 494, 775

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems LU	THERAN MUSCULO	SKELETAL CENTER	?	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2018 To 12/31/2018		pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	S PIII
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	8, 087, 076		8, 087, 07			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 707, 583	l .	1 1,707,00		0	2. 00
3.00	Total (sum of lines 1-2)	22, 794, 659		22, 794, 65			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLILIATION OF CARLTAL COSTS OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS 0			-2, 400, 830	4, 375, 415	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	0			1, 256, 637		2.00
3.00	Total (sum of lines 1-2)	0			0 -1, 144, 193		3. 00
3.00	Total (Sail of Tries 1 2)		SI	JMMARY OF CAPI		4,027,417	3.00
			50	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1712		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		00.000	4/0.00		0 547 405	4 00
1.00	CAP REL COSTS BLDG & FLXT	0	,			2, 517, 135	1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	0	-,		٥	1, 515, 289	2.00
3.00	Total (sum of lines 1-2)	0	88, 970	460, 23	0	4, 032, 424	3. 00

Peri od: Worksheet A-From 01/01/2018 Date/Time Pt

					Fo 12/31/2018		
				Expense Classification on		5/30/2019 3: 48	o piii
				To/From Which the Amount is	to be Adjusted		
	Cost Contor Doscarintian	Paci s/Codo (2)	Amount	Cost Center	lino#	Wkst. A-7 Ref.	
		Basi s/Code (2) 1.00	Amount 2.00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		0			0	
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00		
7. 00	Tel ephone services (pay stations excluded) (chapter 21)	A	-1, 434	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	Television and radio service (chapter 21)	A	-2, 341	CAP REL COSTS-MVBLE EQUIP	2.00	9	
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	-59, 968		0.00	0	9. 00 10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 995, 368			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	9		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of limitation (chapter 14)	7, 0, 0	0	NEOTH THE WIT	00.00		20.00
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	7, 975	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
27. 00	Depreciation - CAP REL	A	-206, 700	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	n	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00		В	-15, 947	CAP REL COSTS-BLDG & FIXT	1.00	10	33. 00

					o 12/31/2018	Date/Time Prep 5/30/2019 3:48	
				Expense Classification on	Worksheet A	070072017 0. 1	Э ріп
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2.00	3. 00	4. 00	5. 00	
33. 01	CABLE EXPENSE	A	-8, 416	OPERATION OF PLANT	7. 00	0	33. 01
33. 02	CABLE EXPENSE	A	-805	PHYSI CAL THERAPY	66.00	0	33. 02
33. 03	FI TNESS REVENUE	В	-130, 384	ADMINISTRATIVE & GENERAL	5.00	0	33. 03
34.00	OTHER MISC REVENUE	В	-12, 225	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MARKETING EXPENSES	A	-1, 136, 315	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSES	A	-176	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	CHARITABLE CONTRIBUTIONS	A	-35, 642	ADMINISTRATIVE & GENERAL	5. 00	0	37.00
38.00	PENALTI ES	A	-806	ADMINISTRATIVE & GENERAL	5. 00	0	38.00
39.00	MI NORI TY I NTEREST	A	-16, 541, 800	ADMINISTRATIVE & GENERAL	5. 00	0	39.00
40.00	COUNTRY CLUB DUES	A	-7, 349	SPORTS MEDICINE	194.00	0	40.00
41.00	PATIENT PHONES - OTHER	A	-1, 700	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
	DEPRECIATION						
42.00	DEPRECIATION ADJ - ADMIN &	A	-436, 861	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
	GENERAL						
50.00	TOTAL (sum of lines 1 thru 49)		-20, 586, 262				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0168 Peri od: Worksheet A-8-1 From 01/01/2018 OFFICE COSTS 12/31/2018 Date/Time Prepared:

				10 12/31/2010	5/30/2019 3: 4	8 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1 00	HOME OFFICE COSTS:	CAD DEL COCTO DI DO 0 FLVT	DACL Comittee Control	(04/	0	1 00
1.00	1	CAP REL COSTS-BLDG & FLXT	PASI Capital Costs - Bldg &	6, 846	0	1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1, 190	172 210	2.00
3. 00 3. 01		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	PASI Operating Costs Shared Service Center Alloca	107, 781	172, 319	3.00
3. 01	l control of the cont	CAP REL COSTS-BLDG & FLXT	New Capital - Building & Fix		363, 600	3. 01 3. 02
3. 02	1	CAP REL COSTS-BLDG & FIXT	New Capital - Building & FIX		0	3. 02
3. 03	l control of the cont	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost		0	3. 03
3. 04	l control of the cont	ADMINISTRATIVE & GENERAL	Malpractice Costs	31, 884	393, 430	3. 04
3. 06		ADMINISTRATIVE & GENERAL	Management Fees	31,004	496, 971	3. 06
3. 00		ADMINISTRATIVE & GENERAL	401K Fees	0	5, 164	3. 00
3. 07	1	ADMINISTRATIVE & GENERAL	Audit Fees	0	51, 434	3. 07
3. 09	1	ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	997, 115	
3. 10	1	ADMINISTRATIVE & GENERAL	HIIM Allocation	0	261, 404	3. 10
3. 10	1	ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	0	22, 574	3. 10
3. 12	1	CAP REL COSTS-BLDG & FIXT	FWO SURGERY CENTER	157, 398	602, 364	3. 11
3. 12	1	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS MRI	137, 370	66, 204	3. 12
3. 14	1	CAP REL COSTS-BLDG & FIXT	FWO CAMPUS PT	87, 161	263, 884	3. 14
3. 15	1	CAP REL COSTS-BLDG & FIXT	TOH RENT / LUTHERAN	447, 807	2, 421, 889	
3. 16	1	ADMINISTRATIVE & GENERAL	TOH RENT / LINEN	100, 969	116, 176	
4. 00	0.00		TOTT KENT / ETNEN	100, 707	110, 170	4. 00
5. 00	TOTALS (sum of lines 1-4).			4, 239, 160	6, 234, 528	5. 00
5. 50	Transfer column 6, line 5 to			1,207,100	5, 201, 020	5. 00
	Worksheet A-8, column 2,					
	line 12.					

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

 The best peeted to her keneet if our amine I and of 27 the amount all onder a be mand attention of the partit					
			Related Organization(s) and/	or Home Office	
					ł
					ĺ
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	COMMUNITY HEALT	60.00 COMMUNITY HEALT	60.00	6.00
7.00	В	LUTHERAN HEALTH	40.00 LUTHERAN HEALTH	40.00	7. 00
8.00	В	HOSPITAL LAUNDR	100.00 HOSPITAL LAUNDR	100.00	8. 00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

9 9 0 3 03 3 03 176, 333 3.04 1, 786, 162 3.04 3.05 -361, 546 0 3.05 0 3.06 -496, 971 3.06 0 3.07 -5, 164 3.07 3.08 -51, 434 0 3.08 0 3.09 -997, 115 3.09 0 3 10 -261, 404 3 10 3.11 -22, 574 3. 11 3.12 -444, 966 9 3. 12 -52, 712 9 9 9 3.13 3.13 -176, 723 3.14 3.14 3.15 -1, 974, 082 3. 15 3.16 -15, 207 3. 16 4.00 0 4.00 -1, 995, 368 5.00 5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	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. 00
7.00	HEALTHCARE	7. 00
	HEALTHCARE	8. 00
9.00		9. 00
10. 00 100. 00		10.00
100.00		100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0168

					-	Γο 12/31/2018	B Date/Time Pre 5/30/2019 3:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	рш
		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		ADMINISTRATIVE & GENERAL	68, 143	50, 068	18, 075	179, 000	95	1. 00
2.00	0.00		0	0	0	0	0	
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			68, 143				95	200. 00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	8.00	9. 00	Educati on 12.00	12 13. 00	14.00	
1. 00		ADMINISTRATIVE & GENERAL	8, 175					1. 00
2. 00	0.00	ADMINISTRATIVE & GENERAL	0, 173			1		2. 00
3. 00	0.00						0	3. 00
4. 00	0.00			0	_	0	0	4. 00
5. 00	0.00		0	0	0	0	l o	
6. 00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	
8. 00	0.00		l o	0	0	l o	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			8, 175	409	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l 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		ADMINISTRATIVE & GENERAL	0		·		•	1. 00
2.00	0.00		0			ı	•	2. 00
3. 00	0.00		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	0			8. 00
9.00	0.00							9. 00
10.00	0. 00		0	0 175	9, 900	F0 0/0		10. 00 200. 00
200.00	1		l 0	8, 175	9, 900	59, 968	I	∠∪∪. ∪∪

	Financial Systems L NLLOCATION - GENERAL SERVICE COSTS	UTHERAN MUSCULOS	Provi der Co	CN: 15-0168 P	eriod: rom 01/01/2018	u of Form CMS-2 Worksheet B Part I Date/Time Pre	
			CADITAL DEL	LATED COSTS	72/31/2010	5/30/2019 3: 4	8 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	ASSUSPENDENCE OF SOME OFFICE OF STATE O	0	1. 00	2. 00	4. 00	4A	
1 00	GENERAL SERVICE COST CENTERS	2 517 135	2 517 125				1 100
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	O0100 CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O0500 ADMINISTRATIVE & GENERAL O0700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DIETARY O1200 MAINTENANCE OF PERSONNEL O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE O1850 OTHER GENERAL SERVICES O1900 NONPHYSICIAN ANESTHETISTS O2000 NURSING SCHOOL O2100 I&R SERVICES-SALARY & FRINGES APPRV O2200 I&R SERVICES-OTHER PRGM COSTS APPRV	2, 517, 135 1, 515, 289 2, 651, 934 11, 154, 278 1, 627, 831 120, 721 456, 312 262, 488 0 947, 154 945, 889 589, 831 755, 821 0	2, 517, 135 0 75, 042 555, 657 0 0 0 140, 614 0 0 0 0 0 0 0 0	1, 515, 289 0 45, 174 334, 500 0 0 0 0	2, 651, 934 717, 414 9, 746 0 0 0 69, 530 84, 761 0 2, 140 0 0	11, 991, 908 2, 527, 734 120, 721 456, 312 262, 488 0 1, 016, 684 1, 255, 912 589, 831 757, 961 0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 12. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	INPATIENT ROUTINE SERVICE COST CENTERS 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	2, 738, 071 0 0 0 0 0 0 0 0 0	341, 955 0 0 0 0 0 0 0 0 0	205, 853 0 0 0 0 0 0 0 0 0	394, 107 0 0 0 0 0 0 0 0 0	3, 679, 986 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
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	11 420 332	751 537	452, 418	919, 350	13 543 637	50.00
51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 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 73. 00 74. 00 75. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C 05600 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06010 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 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART)	11, 420, 332 0 0 0 445, 178 5, 107 0 0 5, 658 2, 063 0 459, 529 0 0 0 18, 688 2, 690, 605 0 23, 619 0 1, 464, 196 13, 588, 504 1, 157, 476 0	751, 537 210, 253 0 0 55, 384 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	126, 570 0 0 33, 341 0 0 0 0 0 0 0 0 0 0 0 0 232, 449 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 33, 556 0 0 0 77 0 540 0 0 420, 568 0 0 0	0 0 5, 658 2, 140 0 460, 069 0 0 0 18, 688 3, 729, 757 0 23, 619 0 1, 464, 196 13, 588, 504 1, 157, 476 0	51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	89. 00 90. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0168	Period: Worksheet B From 01/01/2018 Part I
		To 12/31/2018 Date/Time Prenared

COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	F	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/30/2019 3:4	
		CAPI TAL REI	_ATED COSTS			
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	4A	
OTHER REIMBURSABLE COST CENTERS	0	1.00	2.00	4.00	771	
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	o	0		0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	o	0		0	0	98. 00
99. 00 09900 CMHC	o	0		0	0	99.00
99. 10 09910 CORF	o	0		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0		o	Ō	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	(0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	(0	0	105. 00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	(0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	(0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	(0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115. 00
116. 00 11600 HOSPI CE	0	0	(0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	57, 563, 709	2, 516, 577	1, 514, 953	2, 651, 789	57, 562, 670]118. 00
NONREI MBURSABLE COST CENTERS	ما					1400 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0		0		190. 00 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	15 024	0		145		191.00
193. 00 19300 NONPAID WORKERS	15, 024	0		145	•	192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 SPORTS MEDICINE	2 155 742	U EE0	22/			
194. 00 07950 SPORTS MEDICINE 194. 01 07951 SENIOR CIRCLE	2, 155, 743	558	336		2, 156, 637	194. 00
200.00 Cross Foot Adjustments		0		ا ا		200. 00
201.00 Negative Cost Centers		Ō	,			200.00
202.00 TOTAL (sum lines 118 through 201)	59, 734, 476	2, 517, 135	1, 515, 289	2, 651, 934	59, 734, 476	1
202.00 TOTAL (Suil Titles TTO thi bugit 201)	07, 134, 410	2,017,133	1,010,205	z 2,001,934	57, 154, 410	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm

					12/31/2010	5/30/2019 3:4	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
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
5.00	00500 ADMI NI STRATI VE & GENERAL	11, 991, 908					5. 00
7.00	00700 OPERATION OF PLANT	634, 914	3, 162, 648				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	30, 323	0	151, 044			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	114, 616 65, 931	0	0	570, 928	328, 419	9.00
12. 00		05, 951	0		0	320, 419	10. 00 12. 00
13. 00		255, 370	0	0	0	0	
14. 00		315, 459	235, 742	0	42, 557	0	14. 00
15. 00		148, 153	0	Ö	0	Ö	15. 00
16. 00		190, 384	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	o	0	0	0	0	17. 00
18. 00		0	0	0	0	0	18. 00
19. 00		0	0	0	0	0	19. 00
20. 00	I I	0	0	0	0	0	20. 00
21. 00	1	0	0	0	0	0	21.00
22. 00		0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	Ü	0	23. 00
30. 00		924, 335	573, 295	122, 653	103, 492	328, 419	30.00
31. 00		924, 333	373, 2 7 3	122,000	103, 492	320, 419	31.00
32. 00			0	0	0	0	32.00
33. 00		l o	0	0	0	0	33.00
34.00		o	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	o	0	0	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		0	0	0	0	0	44. 00
45. 00		0	0	0	0	0	45. 00
46. 00		0	0	0	Ü	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 401, 877	1, 259, 966	28, 391	227, 452	0	50.00
51. 00		84, 603	352, 493		63, 633	0	51.00
52. 00		0 1, 000	002, 170	0	00, 000	0	52.00
53. 00		o	Ö	Ö	0	Ö	53.00
54.00		142, 534	92, 853	0	16, 762	0	54.00
54. 01	03630 ULTRA SOUND	1, 283	0	0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00		0	0	0	0	0	56. 00
57. 00		1, 421	0	0	0	0	57. 00
58. 00		538	0	0	0	0	
59. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	59.00
60.00		115, 560	0	0	0	0	60.00
60. 01 61. 00		0	U	0	U	U	60. 01 61. 00
62. 00	1	0	0	0	0	0	62.00
63. 00	1		0	0	0	0	63.00
64. 00	1	o	Ö	Ö	0	Ö	64. 00
65. 00		4, 694	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	936, 837	647, 363	0	116, 863	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	o	0	0	0	0	67.00
68. 00		0	0	0	0	0	68. 00
69. 00		5, 933	0	0	0	0	69. 00
70.00		0	0	0	0	0	70.00
71. 00		367, 775	0] 0	0	0	71.00
72. 00 73. 00		3, 413, 122	0		0	0	72.00
74.00		290, 734	0		0	0	73. 00 74. 00
75. 00			0		0	0	75.00
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			0	<u> </u>	73.00
88. 00		0	0	0	0	0	88. 00
89. 00			0	Ō	0	0	89. 00
90.00		0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	· ·						92. 00
_	OTHER REIMBURSABLE COST CENTERS	1					ļ _
94.00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	94. 00
95. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	
96.00	1	0	0	0	0	0	96.00
97. 00 98. 00	1		0		0	0	97. 00 98. 00
70.00	107000 OTHER REIMBURSABLE COSTS	<u>ı</u>	0	1 0	U	0	70.00

			''	0 12/31/2010	5/30/2019 3: 48 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7.00	8. 00	9. 00	10. 00
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 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	0	0	0 115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 446, 396	3, 161, 712	151, 044	570, 759	328, 419 118. 00
NONRE MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 810	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194. 00 07950 SPORTS MEDICINE	541, 702	936	0	169	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	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	11, 991, 908	3, 162, 648	151, 044	570, 928	328, 419 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm

				10	12/31/2018	5/30/2019 3:4	
	Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON			RECORDS &	
		12. 00	13.00	SUPPLY 14.00	15. 00	LI BRARY 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	4 070 054				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 272, 054	1 040 (70			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	1, 849, 670 1, 018	739, 002		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1,010	739,002	948, 345	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00	01850 OTHER GENERAL SERVICES	0	0	0	Ö	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	o o	Ö	ol	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	o	0	20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	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	440, 449	21, 950	0	22, 321	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 SURGI CAL INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF	0	0	0	U	0	34.00
40. 00 41. 00	04100 SUBPROVI DER - I PF		0	0	0	0	40. 00 41. 00
43. 00	04300 NURSERY		0	0	0	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	Ö	Ö	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	Ö	0	46. 00
	ANCILLARY SERVICE COST CENTERS				-',		
50.00	05000 OPERATING ROOM	0	530, 805	442, 601	0	354, 154	50. 00
51.00	05100 RECOVERY ROOM	0	300, 800	33, 511	o	56, 209	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	0	490	0	17, 643	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	600	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	226	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00	06000 LABORATORY	0	0	11, 116	Ö	11, 809	60.00
60. 01	06001 BLOOD LABORATORY	0	o o	0	ol	0	60. 01
61. 00			_		آ ا		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	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	1, 610	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	9, 463	0	32, 801	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	1 700	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	1, 792	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	120.750	0	0 57 514	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	120, 759 1, 205, 081	0	57, 514 292, 249	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 203, 061	739, 002	99, 403	73.00
74. 00	07400 RENAL DIALYSIS	0	0	0	737,002	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	Ö	Ö	75. 00
. 0. 00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		. 5. 50
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
90.00	09000 CLI NI C	0	0	0	o	0	90. 00
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	<u> </u>					92.00
04.25	OTHER REIMBURSABLE COST CENTERS				-1	-	04.66
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S			0	0	0	94. 00 95. 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED			0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		l 0	0	0	0	97.00
	1	1 0	<u> </u>	٩	<u> </u>		

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part |

			10	12/31/2010	5/30/2019 3:48 pm
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 98.00
99. 00 09900 CMHC	0	0	0	0	0 99.00
99. 10 09910 CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106. 00 10600 HEART 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 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	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)	0	1, 272, 054	1, 845, 989	739, 002	948, 345 118. 00
NONRE MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	12	0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194. 00 07950 SPORTS MEDICINE	0	0	3, 669	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	0 201.00
202.00 TOTAL (sum lines 118 through 201)	0	1, 272, 054	1, 849, 670	739, 002	948, 345 202. 00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168

					o 12/31/2018	Date/Time Pre	
			OTHER GENERAL			5/30/2019 3: 4: INTERNS &	8 pm
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCIAL SERVICE	S	NONPHYSI CI AN	NURSING SCHOOL		
				ANESTHETI STS		Y & FRINGES APPRV	
		17. 00	18. 00	19. 00	20.00	21. 00	
	GENERAL SERVICE COST CENTERS			T			
1.00	00100 CAP REL COSTS-BLDG & FLXT						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	00900 HOUSEKEEPI NG						9. 00
10. 00 12. 00	01000 DI ETARY						10. 00 12. 00
13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
	01600 MEDI CAL RECORDS & LI BRARY	_					16. 00
17. 00	01700 SOCIAL SERVICE	0					17. 00
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			18. 00 19. 00
	02000 NURSI NG SCHOOL	0	Ö		0		20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
23. 00	02300 PARAMED ED PRGM	0	0				23. 00
30. 00	O3000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	0			_	Ö	31. 00
	03200 CORONARY CARE UNIT	0	o	C	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0	C	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF	0	0		0	0	40. 00 41. 00
43. 00	04300 NURSERY	0	0		0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	Ö	C	0	0	44.00
45. 00	04500 NURSING FACILITY	0			0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	0		0	0	50. 00
51. 00	05100 RECOVERY ROOM	0				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	0	0	0	0	54.00
54. 01 55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	54. 01 55. 00
56. 00	05600 RADI OI SOTOPE	0			0	0	56. 00
57. 00	05700 CT SCAN	0	Ö	C	0	0	57. 00
58. 00	05800 MRI	0	0	C	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0		0	0	60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	U	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	Ö	C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	Ö	ď	Ö	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	Ō	C	0	0	75. 00
05 -:	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC					0	89. 00 90. 00
91. 00	09100 EMERGENCY	0	Ö		o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	-	-	-		-	04.55
94.00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0 0	l e			0	
73.00	10,000 NINDOLNINGE SERVI GES	1 0	ı	1	·i U	0	73.00

			'	1270172010	5/30/2019 3: 4	
		OTHER GENERAL			INTERNS &	
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE	S		NURSING SCHOOL		
			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	C	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	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 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		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						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	d	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	d	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
191. 00 19100 RESEARCH	0	0	d	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	d	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	d	0	0	193. 00
194. 00 07950 SPORTS MEDICINE	0	0	d	0	0	194. 00
194. 01 07951 SENI OR CIRCLE	0	0	C	0	0	194. 01
200.00 Cross Foot Adjustments			l c	0	0	200. 00
201.00 Negative Cost Centers	0	0	l c	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	C	0	0	202. 00
		•	•	•	•	

Subtotal Intern & Residents Company Residents Resident	
GENERAL SERVICE COST CENTERS	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
1. 00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
2. 00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
30. 00 03000 ABOLTS & TEBLATIK 03	0 6, 216, 900 30. 00
31.00 03100 INTENSIVE CARE UNIT 0 0 0	0 0 31.00
32. 00 03200 CORONARY CARE UNI T 0 0	0 32.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0	0 0 33.00
40. 00 04000 SUBPROVI DER - PF	0 0 40.00
41. 00 04100 SUBPROVI DER - I RF 0 0 0	0 0 41.00
43. 00 04300 NURSERY 0 0	0 43.00
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 44.00
46. 00 04600 OTHER LONG TERM CARE 0 0 0	0 45.00
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 19, 788, 883	0 19, 788, 883 50. 00
51. 00 05100 RECOVERY ROOM	0 1, 228, 072 51. 00 0 52. 00
53. 00 05300 ANESTHESI OLOGY 0 0	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 837, 741	0 837, 741 54. 00
54. 01 03630 ULTRA SOUND 0 6, 990 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0	0 6, 990 54. 0° 0 55. 00
56. 00 05600 RADI 0I SOTOPE 0 0 0	0 56.00
57. 00 05700 CT SCAN 0 7, 093	0 7, 093 57. 00
58. 00 05800 MRI	0 2, 904 58. 00 0 59. 00
60. 00 06000 LABORATORY	0 598, 554 60. 00
60. 01 06001 BLOOD LABORATORY 0 0	0 60.0
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0 61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0	0 0 62.00
64. 00 06400 NTRAVENOUS THERAPY 0 0 0	0 0 64.00
65. 00 06500 RESPI RATORY THERAPY 0 24, 992	0 24, 992 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 5, 473, 084 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0	0 5, 473, 084 66. 00 0 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0	0 0 68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 31, 344	0 31, 344 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0	0 70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 2, 010, 244 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 18, 498, 956	0 2, 010, 244 71. 00 0 18, 498, 956 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 2, 286, 615	0 2, 286, 615 73. 00
74. 00 07400 RENAL DI ALYSI S	0 74.00
75. 00 O7500 ASC (NON-DISTINCT PART) O O O OUTPATIENT SERVICE COST CENTERS	0 75.00
88. 00 08800 RURAL HEALTH CLINI C 0 0 0	0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0	0 89.00
90. 00 09000 CLI NI C 0 0 0 0 91. 00 0 0 0 0 0 0 0 0 0	0 90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0 91.00
	•

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 5/20/2018 2 48			

COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2018 To 12/31/2018		epared: 18 pm
Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	22. 00	23. 00	24. 00	25. 00	26. 00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	C	
95. 00 09500 AMBULANCE SERVICES	0	0		0	C	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	C	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COSTS	0	0		0	C 	
99. 00 09900 OTHER RETWINDURSABLE COSTS		0		0		
99. 10 09910 CORF		0		0		
100.00 10000 &R SERVICES-NOT APPRVD PRGM		0		0		100.00
101. 00 10100 HOME HEALTH AGENCY		0		0		101.00
SPECIAL PURPOSE COST CENTERS	٩١			<u> </u>		101100
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	C	105. 00
106.00 10600 HEART ACQUISITION	O	0		0 0	C	106. 00
107.00 10700 LIVER ACQUISITION	0	0		0 0	C	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0 0	C	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	C	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600 HOSPI CE		0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	57, 012, 37	2 0	57, 012, 372	1118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0 0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	18, 99	1 0		192. 00
193. 00 19300 NONPALD WORKERS		0	10, 77			193. 00
194. 00 07950 SPORTS MEDI CI NE		0	2, 703, 11	3 0	2, 703, 113	1
194. 01 07951 SENI OR CI RCLE		0	2, 700, 11	o o		194. 01
200.00 Cross Foot Adjustments		0		o o		200.00
201.00 Negative Cost Centers		0		ol o		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	59, 734, 47	6 0		

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

					lo	12/31/2018	Date/lime Pre 5/30/2019 3:4	
				CAPI TAL REI	ATED COSTS			
		Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		cost center bescription	Assigned New	DEDG & TIXI	WVBLL LQOIT	Subtotal	BENEFI TS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS		11.00	2.00	271	11.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	2. 00 4. 00
5.00	1	ADMINISTRATIVE & GENERAL	0	75, 042		120, 216	0	5. 00
7.00		OPERATION OF PLANT	0	555, 657		890, 157	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	0	0	0	0	
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	0	0	0	0	
12. 00		MAINTENANCE OF PERSONNEL	o o	0	Ö	Ö	0	12. 00
13.00		NURSING ADMINISTRATION	O	0	0	О	0	1
14. 00		CENTRAL SERVICES & SUPPLY	0	140, 614	84, 648	225, 262	0	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	0	0	0	0	15. 00 16. 00
17. 00		SOCIAL SERVICE	Ö	Ö	Ö	Ö	0	17. 00
18. 00		OTHER GENERAL SERVICES	0	0	0	0	0	18. 00
19. 00 20. 00		NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	0	0		o	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22. 00
23. 00		PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	l ol	341, 955	205, 853	547, 808	0	30.00
31. 00	1	INTENSIVE CARE UNIT	0	0 341, 733		0	0	1
32.00	03200	CORONARY CARE UNIT	O	0	О	0	0	
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00		SUBPROVI DER - I RF	o	0	Ö	ő	0	41. 00
43.00	1	NURSERY	0	0	0	o	0	43. 00
44. 00	1	SKILLED NURSING FACILITY	0	0	0	0	0	
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0	0		0	0	
.0. 00		LARY SERVICE COST CENTERS	<u> </u>			5		10.00
50.00	1	OPERATI NG ROOM	0	751, 537		1, 203, 955	0	
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	210, 253 0	1	336, 823	0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	0		o	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	55, 384	33, 341	88, 725	0	54.00
54. 01	1	ULTRA SOUND	0	0	0	0	0	54. 01
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00	1	CT SCAN	Ö	Ö	Ö	Ö	0	1
58. 00	05800	•	0	0	0	o	0	00.00
59.00	1	CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	0	0		0	0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY				o		61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0	0	0	0	
65. 00		RESPI RATORY THERAPY	Ö	0	Ö	o	0	
66. 00		PHYSI CAL THERAPY	O	386, 135	232, 449	618, 584	0	66. 00
67. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
68. 00 69. 00		ELECTROCARDI OLOGY	0	0		0	0	
70. 00	1	ELECTROENCEPHALOGRAPHY	0	0	O	Ō	0	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00		RENAL DIALYSIS	0	0	0	ol Ol	0	
75. 00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	1
00.00		TIENT SERVICE COST CENTERS				51		00.00
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00		CLINIC		0		o	0	1
91.00	09100	EMERGENCY	0	0	0	o	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0		92.00
94. 00		HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
			1		1			•

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Provider CCN: 15-0168

			To	12/31/2018	Date/Time Pre 5/30/2019 3:4	pared:
		CAPI TAL REL	ATED COSTS		373072017 3.4	l piii
		OALL TAL INCL	INIED COSTS			
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 SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COSTS	o	0	0	0	0	98. 00
99. 00 09900 CMHC	o	0	0	0	0	99. 00
99. 10 09910 CORF	o	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	o	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	o	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	o	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	o	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	o	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.)	o	0	0	O	0	115. 00
116. 00 11600 HOSPI CE	o	0	0	O	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 0	2, 516, 577	1, 514, 953	4, 031, 530	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	N O	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 SPORTS MEDICINE	0	558	336	894	0	194. 00
194. 01 07951 SENI OR CIRCLE	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	2, 517, 135	1, 515, 289	4, 032, 424	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0168

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/30/2019 3:48 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 00 120, 216 5 00 7.00 00700 OPERATION OF PLANT 6, 365 896, 522 7.00 00800 LAUNDRY & LINEN SERVICE 304 8.00 304 8.00 9.00 00900 HOUSEKEEPI NG 1, 149 1, 149 9.00 C 01000 DI ETARY 0 10.00 10.00 661 C 0 661 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13 00 01300 NURSING ADMINISTRATION 2,560 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 66, 826 14.00 0 14 00 3, 162 86 0 15.00 01500 PHARMACY 1, 485 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,909 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 30.00 9, 266 162, 513 247 208 661 30.00 31.00 03100 INTENSIVE CARE UNIT C 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 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 Λ 34 00 40.00 04000 SUBPROVIDER - IPF 0 C 0 0 0 40.00 04100 SUBPROVI DER - I RF 41.00 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 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 34, 103 357, 166 57 458 0 50.00 05100 RECOVERY ROOM 99, 922 128 0 51.00 51.00 848 C 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 0 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1.429 26, 321 0 34 0 54.00 54.01 03630 ULTRA SOUND 13 0 0 0 0 0 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 0 Ω 0 0 56.00 05600 RADI OI SOTOPE 0 C 0 56.00 05700 CT SCAN 0 57.00 57.00 58.00 05800 MRI 5 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 0 0 60.00 06000 LABORATORY 1, 158 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 65.00 47 0 0 65.00 06600 PHYSI CAL THERAPY 183, 509 66 00 9 392 235 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY C 0 68.00 0 06900 ELECTROCARDI OLOGY 59 0 69.00 C 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 3, 687 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 34, 217 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2.915 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 09850 OTHER REIMBURSABLE COSTS 0 0 98.00 98 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			10	12/31/2018	Date/lime Prepared: 5/30/2019 3:48 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY
, , , , , , , , , , , , , , , , , , ,	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7. 00	8. 00	9. 00	10.00
99. 00 09900 CMHC	0	C	0	0	0 99.00
99. 10 09910 CORF	0	C	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	C	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	C	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS	_				
105.00 10500 KIDNEY ACQUISITION	0	C	0	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	C	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	C	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	C	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	C	0	0	0 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	C		0	0 110. 00
111. 00 11100 SLET ACQUISITION	0	C	이	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	C	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)	114, 748	896, 257	304	1, 149	661 118. 00
NONREI MBURSABLE COST CENTERS			ار	ما	0 190, 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0			O O	0 191.00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES	38			0	0 191.00
193. 00 19300 NONPALD WORKERS	30			0	0 193. 00
194. 00 07950 SPORTS MEDI CI NE	5, 430	265		0	0 194, 00
194. 01 07951 SENI OR CI RCLE	3, 430	200		0	0 194.00
200.00 Cross Foot Adjustments				o _l	200. 00
201.00 Negative Cost Centers	0	(0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	120, 216	896, 522	304	1, 149	661 202. 00
	.2072.0	0,0,022	-1	., ,	30.1 202.1 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti

				10	12/31/2010	Date/lime Pre 5/30/2019 3:4	
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		PERSONNEL	ADMI NI STRATI ON	SERVI CES & 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 EQUI P						2.00
4. 00 5. 00	OO400						4. 00 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 13. 00	01200 MAI NTENANCE OF PERSONNEL	0	2 540				12. 00 13. 00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	2, 560 0	295, 336			14.00
15. 00	01500 PHARMACY	0	0	163	1, 648		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	1, 909	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18.00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	Ö	0	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	886	3, 505	0	48	1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0	0	0	0	31.00
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	04000 SUBPROVI DER - I PF	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	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		10.00
50.00	05000 OPERATING ROOM	0	1, 069	70, 672	0	643	50.00
51. 00	05100 RECOVERY ROOM	0	605	5, 351	0	120	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	0 78	0	0 38	
54. 00	03630 ULTRA SOUND	0	0	70	0	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	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 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0 1, 775	0	0 25	
60. 01	06001 BLOOD LABORATORY	0	0	1, 773	0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		J	J	ŭ	, , , ,	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	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0 1 511	0	3	65.00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0	0	1, 511	0	70 0	
68. 00	06800 SPEECH PATHOLOGY		0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	Ö	0	Ö	0	4	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19, 282	0	123	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	192, 411	0	622	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	1, 648	212	
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
, 5. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	J	<u> </u>	0	0	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	O	0	94.00
	09500 AMBULANCE SERVICES	Ö	0	Ö	0	0	1
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00

			То	12/31/2018	Date/Time Prep 5/30/2019 3:48	
Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	У
		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	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART 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 ISLET 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	0	0		115.00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 560	294, 748	1, 648	1, 909	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	2	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	0	0	586	0		194. 00
194. 01 07951 SENI OR CI RCLE	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	2, 560	295, 336	1, 648	1, 909	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

				'	0 12/31/2018	5/30/2019 3:4	
			OTHER GENERAL			INTERNS &	
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCIAL SERVICE	S S	NONPHYSICI AN	NURSI NG SCHOOL	SERVI CES-SALAR	
				ANESTHETI STS		Y & FRINGES	
		17. 00	18.00	19. 00	20.00	APPRV 21.00	
	GENERAL SERVICE COST CENTERS	17.00	10.00	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	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 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	C)				17. 00
18. 00	01850 OTHER GENERAL SERVICES	C	0)			18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C	0) ()		19. 00
20. 00	02000 NURSI NG SCHOOL	C	0)	0		20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	0			0	
22. 00	O2200 I &R SERVICES-OTHER PRGM COSTS APPRV	C		1			22. 00
23. 00	02300 PARAMED ED PRGM	C) 0)			23. 00
00.05	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-	-				00.00
	03000 ADULTS & PEDIATRICS	C		1			30.00
31.00	03100 I NTENSI VE CARE UNI T	C	l l	1			31.00
32.00	03200 CORONARY CARE UNIT	C	0)			32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0)			33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT)			34. 00
40.00	04000 SUBPROVI DER - I PF						40.00
41.00	04100 SUBPROVI DER - I RF		0				41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY						43.00
45. 00	04500 NURSING FACILITY			1			45. 00
46. 00	04600 OTHER LONG TERM CARE		 	1			46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS) 0	<u>'l</u>			40.00
50.00	05000 OPERATING ROOM	C	0				50.00
51. 00	05100 RECOVERY ROOM			1			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		 	1			52. 00
53. 00	05300 ANESTHESI OLOGY	C	o				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
54. 01	03630 ULTRA SOUND	C	0				54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0				55. 00
56.00	05600 RADI 0I SOTOPE	C	0				56.00
57.00	05700 CT SCAN	C	0				57.00
58.00	05800 MRI	C	0)			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0)			59. 00
60.00	06000 LABORATORY	C	0)			60.00
60. 01	06001 BLOOD LABORATORY	C	0)			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1					61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	0)			62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0)			63. 00
64.00	06400 I NTRAVENOUS THERAPY	C	0	?			64. 00
65. 00	06500 RESPI RATORY THERAPY	C	0	?			65. 00
66.00	06600 PHYSI CAL THERAPY		0				66.00
67.00	06700 OCCUPATIONAL THERAPY		0	(67.00
	06800 SPEECH PATHOLOGY		0				68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY						70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS						71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS						73.00
74.00	07400 RENAL DIALYSIS						74.00
75. 00	07500 ASC (NON-DISTINCT PART)			1			75. 00
73.00	OUTPATIENT SERVICE COST CENTERS		,	1		I	, , 5. 00
88. 00	08800 RURAL HEALTH CLINIC) 0)			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1	1			89. 00
90. 00	09000 CLINIC		1	1			90.00
91. 00	09100 EMERGENCY		1	1			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			1			92.00
00	OTHER REIMBURSABLE COST CENTERS	1					1 00
94. 00	09400 HOME PROGRAM DIALYSIS	C	0)			94. 00
95. 00	09500 AMBULANCE SERVICES	C	I	•			95. 00
	r t t t t t t t t t t t t t t t t t t t		'		1		

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

				0 12/31/2018	5/30/2019 3:4	
		OTHER GENERAL			INTERNS &	
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE	S	NONPHYSICIAN	NURSI NG 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				96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0				98. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0				100. 00
101.00 10100 HOME HEALTH AGENCY	0	0				101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0				105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106. 00
107.00 10700 LIVER ACQUISITION	0	0				107. 00
108.00 10800 LUNG ACQUISITION	0	0				108. 00
109.00 10900 PANCREAS ACQUISITION	0	0				109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0				110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600 HOSPI CE	0	0				116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	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	0				192. 00
193.00 19300 NONPALD WORKERS	0	0				193. 00
194. 00 07950 SPORTS MEDICINE	0	0				194. 00
194. 01 07951 SENI OR CI RCLE	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	0	0	0	202. 00

COST CARTER DESCRIPTION	Health Financial Systems ALLOCATION OF CAPITAL RELATED		UTHERAN MUSCULOS	Provi der CO	CN: 15-0168	Period: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/30/2019 3:4	pared:
DEBIENDED SERVICE COST CENTERS	Cost Center Descri	i pti on	RESIDENTS SERVICES-OTHER PRGM COSTS		Subtotal	Residents Cost & Post Stepdown		S piii
1.00			22. 00	23. 00	24. 00	25. 00	26. 00	
2.00								
INPAIL ENT ROUTH NE SERVICE COST CENTERS 725, 142 0, 725, 142 3.	2. 00 00200 CAP REL COSTS-MVBL 4. 00 00400 EMPLOYEE BENEFITS 5. 00 00500 ADMINISTRATIVE & 0 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 12. 00 01200 MAINTENANCE OF PER 13. 00 01300 NURSING ADMINISTRA 14. 00 01400 CENTRAL SERVICES & 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & 17. 00 01700 SOCIAL SERVICE 18. 00 01850 OTHER GENERAL SERVI 19. 00 01900 NONPHYSICIAN ANEST 20. 00 02000 NURSING SCHOOL 21. 00 02200 I&R SERVICES-SALAF 22. 00 02200 I&R SERVICES-OTHER	LE EQUIP DEPARTMENT GENERAL T ERVICE RSONNEL ATION & SUPPLY LI BRARY VICES THETISTS RY & FRINGES APPRV	0	0				1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00
30.00		CE COST CENTERS						25.00
32 00 03200 03200 03200 03200 03					725, 14	2 0	725, 142	30.00
33.00 03300 BURN INTERSIVE CARE UNIT								
34 00 03400 SURRICAL INTENSIVE CARE UNIT						0		
40, 00 04000 SUBPROVI DER - I IPF 0 0 0 0 0 41								
14. 00 04100 SUBPROVIDER - I IRF		L CAILL OINT						
44. 00 04400 SKILLED NURSING FACILITY						0		
45. 00 04500 NURSI NG FACILITY	1 1					o c		
46.00 04600 OTHER LONG TERM CARE		ACI LI TY				-		
ANCILLARY SERVICE COST CENTERS	1 1	A D F						
SOLO 050000 050000 050000 050000 050000 050000 050000 0500000 05000000 0500000000						<u> </u>	0	40.00
52.00 05200 05200 05200 05200 05200 05200 05200 0530					1, 668, 12	3 0	1, 668, 123	50.00
53.00 05300 AMESTHESI OLOGY 0 0 0 53.	1 1	ADOD DOOM				1		1
S4.00 05400 RADI OLOGY—I LAGNOSTI C 116, 625 0 116, 625 54, 54. 01 03630 ULTRA SOUND 14 54, 54. 01 03630 ULTRA SOUND 0 0 0 0 55, 50. 00 05500 RADI OLOGY—THERAPEUTI C 0 0 0 0 0 55, 56. 00 05600 RADI OLOGY—THERAPEUTI C 0 0 0 0 56, 56. 00 05600 RADI OLOGY—THERAPEUTI C 0 0 0 0 56, 57. 00 05700 CT SCAN 14 0 14 57, 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 5, 58. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59, 60. 00 06000 LABORATORY 2, 958 0 2, 958 0 2, 958 0 0 0 0 0 0 0 0 0	1 1	ABOR ROOM				0		
54.01 03630 ULTRA SOUND 14 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		TIC			116 62	5 0		
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.	1 1	110				1		1
57. 00 05700 CT SCAN 14 0 14 57. 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	1 1	JTI C			i e			1
58. 00 05800 MRI 5 0 5 58. 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 58. 60. 00 00000 LABORATORY 2,958 0 2,958 60. 00 00000 LABORATORY 0 0 0 0 0 60. 00 00000 DEBORATORY 0 0 0 0 0 0 0 0 0						-		
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.					1	4 0		
60. 00 06000 LABORATORY 2, 958 0 2, 958 60. 00 0 0 0 0 0 0 0 0	1 1	7.A.T.I. O.N.						
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 60. 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 62. 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63. 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64. 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 64. 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 813, 301 66. 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 68. 69. 00 0700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 69. 00 0700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 69. 00 0700 ORDOO ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 23, 092 0 23, 092 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 227, 250 0 227, 250 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 227, 250 0 227, 250 72. 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 75. 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 88. 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 990. 90. 00 09000 CLI NI C 0 0 0 0 990. 91. 00 09100 EMERGENCY 0 0 0 0 0 0 990.	1 1	ZATTON			2 95	8 0		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 75. 00 06600 PHYSI CAL THERAPY 75. 00 06700 OCCUPATI ONAL THERAPY 75. 00 06700 OCCUPATI ONAL THERAPY 75. 00 07000 ELECTROCARDI OLOGY 75. 00 07000 ELECTROCARDI OLOGY 75. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 75. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 07500 DRUGS CHARGED TO PATI ENTS 77. 00 07500 DRUGS CHARGED TO PATI ENTS 78. 00 07500 DRUGS CHARGED TO PATI ENTS 79. 00 07500 DRUGS CHARGED	1 1				_,	o o		1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	61.00 06100 PBP CLINICAL LAB S	SERVICES-PRGM ONLY						61.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64.065.00 06500 RESPIRATORY THERAPY 50 0 50 65.065.00 06500 RESPIRATORY THERAPY 50 0 0 50 65.065.00 06600 PHYSI CAL THERAPY 813, 301 0 813, 301 66.07.00 06700 00CCUPATI ONAL THERAPY 0 0 0 0 0 67.09.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 06900 ELECTROCARDI OLOGY 63 0 0 63 69.00 070000 070000 07000 070000 070000 070000 070000 070000 070000 070000 070000 070000	1					0		1
65. 00 06500 RESPIRATORY THERAPY 50 0 50 65.	1 1					0		
66. 00 06600 PHYSI CAL THERAPY 813, 301 0 813, 301 66.	1				5			
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67. 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 68. 69. 00 06900 ELECTROCARDI OLOGY 63 0 63 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 23, 092 0 23, 092 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 227, 250 0 227, 250 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 227, 250 0 227, 250 72. 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 89. 99. 00 09900 EDEBRALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 91. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 0 0 0 0 0 0 0 0 0	1 1	T 1			•			1
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68.		APY			1 210, 30	ol öl		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 07100 07						0	0	68. 00
71. 00	1 1				6	3 0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 227, 250 0 227, 250 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 775 0 4, 775 73. 74. 00 07400 RENAL DIALYSIS 0 0 0 0 74. 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.	1 1				22.00			
73. 00 07300 DRUGS CHARGED TO PATIENTS 4,775 0 4,775 73. 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 74. 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75. OUTPATIENT SERVICE COST CENTERS 0 0 0 0 88. 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 89. 90. 00 09900 CLINIC 0 0 0 90. 91. 00 09100 EMERGENCY 0 0 0 91.	1 1					1		1
74. 00						1		1
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 888. 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 99. 90. 00 09000 CLINIC 0 0 0 99. 91. 00 09100 EMERGENCY 0 0 0 91.	1 1	•				1		1
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 90. 00 09000 CLINIC 0 0 0 90. 91. 00 09100 EMERGENCY 0 0 0 0 91.	75. 00 07500 ASC (NON-DISTINCT					0 0	0	75. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					T			00 -
90. 00 09000 CLI NI C 0 0 90. 0 91. 0 0 0 0 91. 0 0 0 0 91. 0 0 0 0 91. 0 0 0 91. 0 0 0 91. 0 0 0 91. 0 0 0 91. 0 0 0 91. 0 0 0 91. 0 0 0 0 0 0 0 91. 0 0 0 0 0 0 0 0 0	1 1				i			
91. 00 09100 EMERGENCY 0 0 91.	1 1	LU NEALIN CENTEK			i			
						-		
72. 00 07200 050ERVATI ON DEDU (NON DI OTTNOT TAKT		(NON-DISTINCT PART				o		92.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/30/2019 3:4	pared: 8 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				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		95. 00 96. 00 97. 00 98. 00 99. 00
SPECIAL PURPOSE COST CENTERS			l	0 0		101.00
105. 00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 108.00 108.00 109.00 109.00 109.00 110.00 111.00 111.00 111.00 111.00 111.00 115.00 115.00 115.00 115.00 116.00 116.00 116.00 116.00 116.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 100 1000 10	0	0	4, 025, 2		0 0 0 0 0 0 0 4,025,209	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 194.00 07950 SPORTS MEDICINE 194.01 07951 SENIOR CIRCLE 200.00 Cross Foot Adjustments Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 0 0	0 0 0	7, 1	0 0 0 0 0 0	0 40 0 7, 175 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 01 200. 00 201. 00 202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 126, 256 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 126, 256 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 15, 061, 961 4.00 4, 074, 642 -11, 991, 908 47, 742, 568 5 00 00500 ADMINISTRATIVE & GENERAL 3 764 5 00 3.764 7.00 00700 OPERATION OF PLANT 27,871 27,871 55, 356 2, 527, 734 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 120, 721 8.00 0 00900 HOUSEKEEPI NG 0 0 456, 312 9.00 9.00 0 01000 DI ETARY 0 0 10 00 10 00 C 262, 488 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 01300 NURSING ADMINISTRATION 0 13.00 394, 907 0 1, 016, 684 13.00 01400 CENTRAL SERVICES & SUPPLY 7,053 1, 255, 912 14.00 7.053 481, 410 14.00 15.00 01500 PHARMACY 0 589, 831 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 12, 154 757, 961 16.00 C 01700 SOCIAL SERVICE 0 17.00 C 17.00 0 0 01850 OTHER GENERAL SERVICES 0 18.00 C 0 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 19 00 02000 NURSING SCHOOL 0 0 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 22.00 C 0 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 152 17, 152 2, 238, 382 3, 679, 986 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 0 34.00 0 0 40.00 04000 SUBPROVI DER - I PF C 0 0 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 41.00 0 0 43.00 04300 NURSERY 0 0 0 43.00 0 04400 SKILLED NURSING FACILITY 0 44 00 Λ 44 00 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 37.696 37, 696 5, 221, 525 0 13, 543, 637 50.00 51.00 05100 RECOVERY ROOM 10,546 10, 546 C 0 336, 823 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 53 00 05300 ANESTHESI OLOGY 0 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,778 2,778 190, 584 567, 459 54.00 54.01 03630 ULTRA SOUND 5, 107 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 55.00 05600 RADI OI SOTOPE 0 56 00 0 0 56 00 57.00 05700 CT SCAN 0 0 5,658 57.00 05800 MRI 0 440 0 2, 140 58.00 58.00 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 C 0 0 460, 069 60.00 06000 LABORATORY 3.067 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 0 62.00 0 Ω 62.00 06300 BLOOD STORING, PROCESSING & TRANS 0 0 63.00 C 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 06500 RESPIRATORY THERAPY 65.00 0 18,688 65.00 06600 PHYSI CAL THERAPY 19.368 19, 368 2, 388, 668 3, 729, 757 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0 68.00 0 0 06900 ELECTROCARDI OLOGY 69.00 0 0 23, 619 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 1, 464, 196 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 13, 588, 504 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 157, 476 73.00 0 73.00 0 0 0 74.00 07400 RENAL DIALYSIS r 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 o 91.00 91.00 0

92.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm CAPITAL RELATED COSTS MVBLE EQUIP Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) **BENEFITS** & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 94 00 O 00000 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 Ω 0 09850 OTHER REIMBURSABLE COSTS 0 98.00 98.00 0 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 0000 106.00 10600 HEART ACQUISITION 0 0 0 106.00 Ω 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108.00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM_OF_LINES_1 through 117) -11, 991, 908 45, 570, 762 118. 00 118.00 126, 228 126, 228 15, 061, 135 NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 826 15, 169 192. 00 193. 00 19300 NONPALD WORKERS 0 r 0 0 193. 00 194.00 07950 SPORTS MEDICINE 28 2, 156, 637 194. 00 28 0 194. 01 07951 SENI OR CIRCLE 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, 11, 991, 908 202. 00 2, 517, 135 1, 515, 289 2, 651, 934 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 12.001719 0. 251179 203. 00 19. 936755 0.176068 Cost to be allocated (per Wkst. B, 120, 216 204. 00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.002518 205.00 H) 206.00 NAHE adjustment amount to be allocated 206. 00

207. 00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

Period: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm

Cost Center Description	OPERATION OI PLANT (SQUARE FEET	LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	5/30/2019 3: 4 MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	8 pm
	7. 00	8. 00	9. 00	10.00	12. 00	
GENERAL SERVICE COST CENTERS	94, 6.	0 134, 880 0 0 0 0 0 0 0 0 0 0 53 0	94, 621 0 0 0	17, 374 0 0 0	0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 18. 00 01850 OTHER GENERAL SERVI CES 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI 22. 00 02200 I &R SERVI CES-OTHER PRGM CO 23. 00 02300 PARAMED ED PRGM INPATI ENT ROUTI NE SERVI CE COST	NGES APPRV OSTS APPRV CENTERS	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	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY 46. 00 04500 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	17, 1!	52 109, 527 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 0 0 0 0 0 0	17, 374 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROO 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES 62. 00 06200 WHOLE BLOOD & PACKED RED 63. 00 06300 BLOOD STORI NG, PROCESSI NG 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSIS	2, 7 E-PRGM ONLY BLOOD CELL & TRANS. 19, 36	46 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 546 0 0 2, 778 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	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	H CENTER	0 0 0 0 0 0 0 0 0 0		0 0 0 0 0	0 0 0 0	75. 00 88. 00 89. 00 90. 00 91. 00 92. 00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-REM		0 0 0 0 0 0	·	0 0	0 0	94. 00 95. 00 96. 00

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

				T	o 12/31/2018	Date/Time Pre 5/30/2019 3:4	
Co	ost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF	
	·	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	PERSONNEL	
		(SQUARE FEET)	(POUNDS OF			(NUMBER	
			LAUNDRY)			HOUSED)	
		7. 00	8. 00	9. 00	10.00	12. 00	
	URABLE MEDICAL EQUIP-SOLD	0	0	ŭ	_	ı	97. 00
	THER REIMBURSABLE COSTS	0	0	0	0	0	98. 00
99. 00 09900 CI		0	0	0	0	0	99. 00
99. 10 09910 C		0	0	0	0	0	99. 10
	&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	OME HEALTH AGENCY	0	0	0	0	0	101. 00
	PURPOSE COST CENTERS	_1		_	_		
	IDNEY ACQUISITION	0	0	_		_	105. 00
	EART ACQUISITION	0	0	0	_		106. 00
	I VER ACQUI SI TI ON	0	0	0	0		107. 00
	UNG ACQUISITION	0	0	0	0		108. 00
	ANCREAS ACQUISITION	0	0	0	0		109. 00
	NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
	SLET ACQUISITION	0	0	0	0		111. 00
	NTEREST EXPENSE						113.00
	TILIZATION REVIEW-SNF						114. 00
	MBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116. 00 11600 H		0	0	0	0		116. 00
	UBTOTALS (SUM OF LINES 1 through 117)	94, 593	134, 880	94, 593	17, 374	0	118. 00
	BURSABLE COST CENTERS IFT, FLOWER, COFFEE SHOP & CANTEEN	ما	0	0	0	0	190. 00
190. 00 19000 GI		0	0	ŭ	_		190.00
		U	0	0	0		
	HYSICIANS' PRIVATE OFFICES ONPAID WORKERS	0	0	0	0		192. 00 193. 00
	PORTS MEDICINE	0	0	20	0		193.00
194. 00 07950 SF		28	0	28	0		194. 00
	ross Foot Adjustments	U	U	U	U		200. 00
	egative Cost Centers						200.00
	ost to be allocated (per Wkst. B,	3, 162, 648	151, 044	570, 928	328, 419		201.00
	art I)		131, 044	570, 926	·	U	202.00
	nit cost multiplier (Wkst. B, Part I)	33. 424377	1. 119840	6. 033840	18. 902901	0.000000	203. 00
204. 00 Co	ost to be allocated (per Wkst. B,	896, 522	304	1, 149	661	0	204. 00
	art II)						
205. 00 Ur	nit cost multiplier (Wkst. B, Part	9. 474873	0. 002254	0. 012143	0. 038045	0.000000	205. 00
	1)						
	AHE adjustment amount to be allocated						206. 00
1 1	per Wkst. B-2)						
	AHE unit cost multiplier (Wkst. D,						207. 00
Pa	arts III and IV)						

1. 00 C 2. 00 C 4. 00 C 5. 00 C 7. 00 C 8. 00 C 10. 00 C 12. 00 C	Cost Center Description Cost Center Description GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0700 OPERATION OF PLANT	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13.00	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)		MEDI CAL RECORDS & LI BRARY		
1. 00	GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL	ADMI NI STRATI ON (DI RECT NRSI NG HRS)	SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED	MEDI CAL RECORDS & LI BRARY	5/30/2019 3: 4 SOCIAL SERVICE	
1. 00	GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL	ADMI NI STRATI ON (DI RECT NRSI NG HRS)	SERVI CES & SUPPLY (COSTED REQUI S.)	(COSTED	RECORDS & LI BRARY		
1. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	(DI RECT NRSI NG HRS)	SUPPLY (COSTED REQUIS.)		LI BRARY	(TIME SPENT)	
1. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	HRS)	(COSTED REQUIS.)				
1. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL				(GROSS CHAR	(112 01 2.11)	
1. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	13.00	14. 00	15. 00	GES) 16. 00	17. 00	
2.00 (0 4.00 (0 5.00 (0 7.00 (0 8.00 (0 9.00 (0 10.00 (0 12.00 (0	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL		14.00	15.00	10.00	17.00	
4. 00 0 5. 00 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 12. 00 0	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1. 00
5. 00 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 12. 00 0	DO500 ADMINISTRATIVE & GENERAL						2. 00 4. 00
8. 00 0 9. 00 0 10. 00 0 12. 00 0	OOZOO ODEDATION OF DIANT						5.00
9. 00 0 10. 00 0 12. 00 0							7. 00
10. 00 0 12. 00 0	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING						8. 00 9. 00
	01000 DI ETARY						10.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMI NI STRATI ON	145, 597 0	20, 999, 909				13. 00 14. 00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	11, 561	1, 157, 476			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	504, 911, 086		16.00
	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	U 0	0	18. 00 19. 00
20.00	02000 NURSI NG SCHOOL		o	0	ő	0	20.00
	D2100 &R SERVICES-SALARY & FRINGES APPRV	0	o	0	o	0	21.00
	D2200 1&R SERVICES-OTHER PRGM COSTS APPRV D2300 PARAMED ED PRGM	0	O O	0	U 0	0	22. 00 23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	J		25.00
	03000 ADULTS & PEDIATRICS	50, 413	249, 202	0	11, 885, 340	0	30.00
	D3100 INTENSIVE CARE UNIT D3200 CORONARY CARE UNIT	0	0	0	0	0	31. 00 32. 00
	03300 BURN INTENSIVE CARE UNIT	0	o	0	, 0	o o	33.00
	03400 SURGICAL INTENSIVE CARE UNIT	O	o	0	o	0	34.00
	04000 SUBPROVI DER	0	0	0	0	0	40. 00 41. 00
	04300 NURSERY	0	o	0	, 0	Ö	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	o	0	44.00
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
-	ANCILLARY SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		10.00
	D5000 OPERATING ROOM	60, 755	5, 024, 993	0			50.00
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	34, 429	380, 463	0	29, 930, 173 0	0	51. 00 52. 00
	05300 ANESTHESI OLOGY	0	Ö	0	, o	ő	53.00
4	D5400 RADI OLOGY-DI AGNOSTI C	0	5, 560	0	9, 394, 511	0	54.00
	D3630 ULTRA SOUND D5500 RADI OLOGY-THERAPEUTI C	0	O O	0	319, 421	0	54. 01 55. 00
	05600 RADI OI SOTOPE	0	o	0	, o	o o	56.00
	D5700 CT SCAN	0	0	0	7, 479		57.00
	D5800 MRI D5900 CARDI AC CATHETERI ZATI ON	0	0	0	120, 317 0	0	58. 00 59. 00
	06000 LABORATORY	0	126, 201	0	6, 288, 052	Ö	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY D6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	0	61. 00 62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	o o	63.00
1	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	107, 440	0	857, 109 17, 466, 185	0	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	17, 400, 103	o o	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	954, 110 0	0	69. 00 70. 00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 371, 010	0	30, 625, 090	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 681, 690	0	155, 617, 065	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	1, 157, 476 0	52, 930, 189	0	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)		ol	0	0	0	75.00
C	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	o	0	88.00
	D8900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89. 00 90. 00
91.00	09100 EMERGENCY	Ö	ō	Ō	ol	Ö	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS OP400 HOME PROGRAM DIALYSIS	0	o	0	0	0	94.00
	09500 AMBULANCE SERVICES	Ö	ō	Ö	-	1	

	<i>y</i>	THERAIN WUSCULUS			111 111	u or roriii cws-	
COST ALLOCA	FION - STATISTICAL BASIS		Provi der Co	CN: 15-0168	Peri od:	Worksheet B-1	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/30/2019 3: 4	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRSING	(COSTED		(GROSS CHAR		
		HRS)	REQUIS.)		GES)		
		13. 00	14. 00	15. 00	16.00	17. 00	
96 00 09600	DURABLE MEDICAL EQUIP-RENTED	0		10.00	0 0		96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0			j ő	
		0	0				
	OTHER REIMBURSABLE COSTS	0	0		0	0	
99. 00 09900		0	0		0 0	0	
99. 10 09910	CORF	0	0		0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101. 00 10100	HOME HEALTH AGENCY	0	0		0 0	0	101.00
	AL PURPOSE COST CENTERS	-1					
	KIDNEY ACQUISITION	0	0		0 0	1	105. 00
	HEART ACQUISITION	0	0			•	106. 00
	l .	0	0		-	•	
	LIVER ACQUISITION	0	0		0 0		107. 00
	LUNG ACQUISITION	0	0		0 0	1	108. 00
109. 00 10900	PANCREAS ACQUISITION	0	0		0	0	109. 00
110.00 11000	INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111. 00 11100	I SLET ACQUI SI TI ON	ol	0		0 0	0	111. 00
	INTEREST EXPENSE						113. 00
	UTI LI ZATI ON REVI EW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)		0				115. 00
		0	0				
116. 00 11600		0	0		0	1	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	145, 597	20, 958, 120	1, 157, 4	76 504, 911, 086	0	118. 00
	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
191. 00 19100	RESEARCH	0	0		0 0	0	191. 00
192, 00 19200	PHYSICIANS' PRIVATE OFFICES	ol	139		0 0	0	192.00
	NONPALD WORKERS	0	0		0	1	193. 00
	SPORTS MEDICINE	0	41, 650			1	194. 00
1	SENI OR CI RCLE	0	41,030			•	194. 01
1	l .	٩	U			'	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 272, 054	1, 849, 670	739, 0	02 948, 345	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 736815	0. 088080	0. 6384	60 0. 001878	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	2, 560	295, 336	1, 6	48 1, 909	0	204.00
	Part II)	, , , , ,		, ,	,		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 017583	0. 014064	0. 0014	24 0. 000004	0.000000	205 00
200.00	II)	0.017000	0.011001	0.0011	0.00000	0.00000	200.00
206. 00	1 ,						206. 00
200.00	NAHE adjustment amount to be allocated						200.00
207.00	(per Wkst. B-2)						207 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	1		I		I	1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0168 Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					0 12/31/2018	5/30/2019 3:4	
		OTHER GENERAL SERVICE			INTERNS &	RESI DENTS	
	Cost Center Description	S	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	
		(TIME SPENT)	ANESTHETI STS	(ACCLONED	Y & FRINGES	PRGM COSTS	
			(ASSIGNED TIME)	(ASSI GNED TI ME)	APPRV (ASSI GNED	APPRV (ASSI GNED	
			TTWE)	TTWE)	TIME)	TI ME)	
	CENEDAL CEDULCE COCT CENTEDO	18. 00	19. 00	20.00	21. 00	22. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 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 ADMI NI STRATI VE & GENERAL						5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG			•			9. 00
10. 00	01000 DI ETARY						10. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00 19. 00	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0				18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0		Ö			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0				0	22. 00
23. 00	02300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS	0					23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	O	0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	_	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	_	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		_	0	40.00
41. 00	04100 SUBPROVI DER – I RF	0	0	Ö	_	0	41. 00
43.00	04300 NURSERY	0	0	0	_	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0		0	44.00
45. 00 46. 00	04500 OTHER LONG TERM CARE	0				0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS	_		_	_		
50.00	05000 OPERATI NG ROOM	0	0	1		0	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	_	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	O	0	0	54. 00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
	05700 CT SCAN	0	Ö			0	57. 00
	05800 MRI	0	0			0	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	0) 0	0	ı .	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					Ŭ	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. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00
64. 00 65. 00	06500 RESPIRATORY THERAPY	0	0		0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Ö	Ö	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	_	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	_	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	Ö	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	_	0	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	•		0	74. 00 75. 00
, 5. 00	OUTPATIENT SERVICE COST CENTERS		·	· · · · · ·		0	, , 5. 50
	08800 RURAL HEALTH CLINIC	0	0	•	_	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89. 00
	09000 CLI NI C 09100 EMERGENCY	0	0	0	0	0	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ				92. 00

				1	0 12/31/2018	5/30/2019 3:4	
		OTHER GENERAL			INTERNS &	RESI DENTS	J pili
		SERVI CE					
(Cost Center Description	S	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	
	p	(TIME SPENT)	ANESTHETI STS		Y & FRINGES	PRGM COSTS	
		,	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
			, i	,	TIME)	TIME)	
		18. 00	19. 00	20.00	21.00	22. 00	
	REIMBURSABLE COST CENTERS						
1 1	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 [DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
	OTHER REIMBURSABLE COSTS	0	0	0	0	0	98.00
99. 00 09900		0	0	0	0	0	99. 00
99. 10 09910	CORF	0	0	0	0	0	99. 10
100.00 10000 1	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101. 00 10100 I	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECI A	L PURPOSE COST CENTERS						
105. 00 10500 I	KIDNEY ACQUISITION	0	0	0	0	0	105.00
	HEART ACQUISITION	0	0	0	0	0	106.00
107. 00 10700 I	LIVER ACQUISITION	0	0	0	0	0	107.00
108. 00 10800 I	LUNG ACQUISITION	0	0	0	0	0	108.00
109. 00 10900 I	PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111. 00 11100	ISLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 1	INTEREST EXPENSE						113. 00
114. 00 11400 l	UTILIZATION REVIEW-SNF						114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 I	HOSPI CE	0		0)		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118. 00
NONREI	MBURSABLE COST CENTERS						
190. 00 19000 (GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 I	RESEARCH	0	0	0	0	0	191. 00
192. 00 19200 I	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 [NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950	SPORTS MEDICINE	0	0	0	0	0	194.00
194. 01 07951	SENI OR CIRCLE	0	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	0	Ō	0	0	0	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	0.000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	o	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
	II)						
	NAHE adjustment amount to be allocated			0)		206. 00
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D,			0.000000			207. 00
	Parts III and IV)						

Health FinancialSystemsLUTHERAN MUSCULOSKELETAL CENTERIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-0168Period:Worksheet B-1

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 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 INTRAVENOUS 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 09400 HOME PROGRAM DIALYSIS 94.00 94 00 0 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0168	Peri od: Worksheet B-1
		From 01/01/2018 Date/Time Prepared:

COST AL	LEGGATION STATISTICAL BASIS		11 0V1 del Celv. 13 0100	From 01/01/2018	WOLKSHEET D 1	
					Date/Time Prepare 5/30/2019 3:48 pt	
	Cost Center Description	PARAMED ED			3/30/2019 3.46 p	וווכ
	oost denter beserretron	PRGM				
		(ASSI GNED				
		TIME)				
		23. 00				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0			97	7. 00
98. 00	09850 OTHER REIMBURSABLE COSTS	0			98	8.00
	09900 CMHC	0			99	9.00
	09910 CORF	0			99	9. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0			· · · · · · · · · · · · · · · · · · ·	0. 00
	10100 HOME HEALTH AGENCY	0			101	1. 00
	SPECIAL PURPOSE COST CENTERS					
- 1	10500 KIDNEY ACQUISITION	0				5.00
	10600 HEART ACQUISITION	0				6. 00
	10700 LIVER ACQUISITION	0				7. 00
	10800 LUNG ACQUISITION	0				8. 00
	10900 PANCREAS ACQUISITION	0				9. 00
	11000 NTESTI NAL ACQUI SI TI ON	0				0.00
	11100 SLET ACQUI SITI ON	0				1.00
	11300 I NTEREST EXPENSE				l	3.00
	11400 UTI LI ZATI ON REVI EW-SNF					4.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			l	5.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0				6. 00 8. 00
	NONREI MBURSABLE COST CENTERS	U U			110	0. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O			190	0. 00
	19100 RESEARCH					1. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0				2. 00
	19300 NONPALD WORKERS					3. 00
	07950 SPORTS MEDICINE					4. 00
	07951 SENI OR CI RCLE					4. 01
200.00	Cross Foot Adjustments					0. 00
201.00	Negative Cost Centers					1. 00
202.00	Cost to be allocated (per Wkst. B,	o			202	2. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000				3. 00
204.00	Cost to be allocated (per Wkst. B,	0			204	4.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000			205	5.00
	11)					
206.00	NAHE adjustment amount to be allocated	0			206	6. 00
007.05	(per Wkst. B-2)	0.00000				
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000			207	7. 00
	Parts III and IV)				1	

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018		pared:
			Title	e XVIII	Hospi tal	5/30/2019 3: 4 PPS	8 pm
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs	Total Costs	
	cost center bescription	(from Wkst. B, Part I, col.	Adj .	Total Costs	Di sal I owance	Total Costs	
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 216, 900		6, 216, 90	0 0	6, 216, 900 0	1
32.00	03200 CORONARY CARE UNIT	0			0 0	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF	0			0 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 0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0			0 0	0	
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0			0 0	0	46. 00
50.00	05000 OPERATI NG ROOM	19, 788, 883		19, 788, 88			1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 228, 072		1, 228, 07	0 0	1, 228, 072 0	
53. 00	05300 ANESTHESI OLOGY	Ö			0 0	ő	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	837, 741		837, 74		837, 741	
54. 01 55. 00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	6, 990		6, 99	0 0	6, 990 0	
56.00	05600 RADI OI SOTOPE	0			0 0	0	00.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	7, 093 2, 904		7, 09 2, 90		7, 093 2, 904	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59. 00
60.00	06000 LABORATORY	598, 554		598, 55	0	598, 554	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0 0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0 0	0	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	24, 992	o	24, 99	2 0	24, 992	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 473, 084	0	5, 473, 08	0	5, 473, 084 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö		0 0	Ö	1
69.00	06900 ELECTROCARDI OLOGY	31, 344		31, 34	4 0	31, 344	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 010, 244		2, 010, 24	4 0	2, 010, 244	70.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	18, 498, 956	l e	18, 498, 95		18, 498, 956	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	2, 286, 615		2, 286, 61	0 0	2, 286, 615 0	1
	07500 ASC (NON-DISTINCT PART)	0			0 0	0	
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	1 0		I	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0			0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	579, 913		579, 91	3	579, 913	
94. 00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DIALYSIS	1 0		1	0 0	0	94.00
	09500 AMBULANCE SERVICES	0			0 0		
	09600 DURABLE MEDICAL EQUI P-RENTED	0			0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COSTS				0 0	0	
99. 00	09900 CMHC	0			0	0	99. 00
	09910 CORF 10000 L&R SERVICES-NOT APPRVD PRGM	0			0	0	99. 10 100. 00
	10100 HOME HEALTH AGENCY	0		j	0		101. 00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0			0	0	105. 00
106.00	10600 HEART ACQUISITION	0			0	0	106. 00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0			0		107. 00 108. 00
	10900 PANCREAS ACQUISITION	0			0		109.00
	11000 INTESTINAL ACQUISITION	0			0		110.00
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE						111. 00 113. 00
114.00	11400 UTILIZATION REVIEW-SNF	_				_	114. 00
	11500 AMBULATORY SURGICAL CENTER (D.P.) 11600 HOSPICE	0		-	0		115. 00 116. 00
200.00		57, 592, 285	<u> </u> 0	57, 592, 28	0	l	

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	P		Provider CCN: 15-0168		Peri od:	Worksheet C	
					From 01/01/2018 To 12/31/2018		pared: 8 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
Cost Center Description	Total Cost (from Wkst. B,		ıpy Limit Adi.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.						
	1. 00	2	2. 00	3. 00	4. 00	5. 00	
201.00 Less Observation Beds	579, 913			579, 9	3	579, 913	201. 00
202.00 Total (see instructions)	57, 012, 372		o	57, 012, 37	['] 2 0	57, 012, 372	202. 00

COMPUT		cial Systems LU OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0168	Peri od: From 01/01/2018	u of Form CMS- Worksheet C Part I	
						To 12/31/2018	Date/Time Pre 5/30/2019 3:4	epared: 18 pm
					XVIII	Hospi tal	PPS	_
		Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
			6.00	7. 00	8. 00	9. 00	10.00	
		ENT ROUTINE SERVICE COST CENTERS	10.705.040		1 40 705 04			
30.00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	10, 725, 069		10, 725, 06	0		30.00
32. 00		CORONARY CARE UNIT				0		32. 00
33. 00		BURN INTENSIVE CARE UNIT	O			0		33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0			0		34.00
40.00		SUBPROVI DER - I PF	0			0		40.00
41. 00 43. 00		SUBPROVI DER - I RF NURSERY	0			0		41.00
		SKILLED NURSING FACILITY				0		44. 00
45. 00		NURSING FACILITY	Ö			0		45. 00
46. 00		OTHER LONG TERM CARE	0			0		46. 00
FO 00		ARY SERVICE COST CENTERS	70,000,007	117 712 700	100 51/ 0/	0 104070	0.000000	T 50 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	70, 802, 337 11, 406, 565	117, 713, 708 18, 523, 608			0. 000000 0. 000000	
52. 00		DELIVERY ROOM & LABOR ROOM	0	18, 323, 608		0.000000	0. 000000	
53.00	05300	ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53.00
54.00	1	RADI OLOGY-DI AGNOSTI C	1, 360, 963	8, 033, 548			0. 000000	
54. 01		ULTRA SOUND	294, 394	25, 027	319, 42		0.000000	
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE		0		0.000000 0.000000	0. 000000 0. 000000	
57. 00		CT SCAN	7, 479	0	7, 47		0. 000000	
58. 00	05800	MRI	120, 317	0	120, 31		0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	0	0		0.000000	0. 000000	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	4, 388, 393	1, 899, 659	6, 288, 05	0. 095189 0. 000000	0. 000000 0. 000000	
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0.000000	0. 000000	
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		0.000000	0. 000000	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	63.00
64.00	1	I NTRAVENOUS THERAPY	0	0	057.40	0.000000	0.000000	
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	668, 107 1, 698, 204	189, 002 15, 767, 981	857, 10 17, 466, 18		0. 000000 0. 000000	
67. 00		OCCUPATIONAL THERAPY	1, 048, 204	15, 767, 761	17, 400, 10	0. 000000	0. 000000	
68. 00		SPEECH PATHOLOGY	Ö	0		0.000000	0. 000000	
69. 00		ELECTROCARDI OLOGY	233, 007	721, 103	954, 11		0. 000000	
70.00		ELECTROENCEPHALOGRAPHY	0	0	20 /25 00	0.000000	0.000000	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	10, 066, 385 105, 245, 425	20, 558, 705 50, 371, 640		1	0. 000000 0. 000000	
		DRUGS CHARGED TO PATIENTS	21, 357, 156	31, 573, 033			0. 000000	•
		RENAL DIALYSIS	0	0		0. 000000	0. 000000	74.00
75. 00		ASC (NON-DISTINCT PART)	0	0		0.000000	0. 000000	75. 00
88. 00		FIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0				88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	o	0		0		89. 00
90. 00		CLINIC	0	0		0. 000000	0. 000000	
91.00		EMERGENCY	0	0	4 4/0 0	0.000000	0.000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	39, 637	1, 120, 634	1, 160, 27	0. 499808	0. 000000	92.00
94. 00		HOME PROGRAM DIALYSIS	0	0		0. 000000	0. 000000	94.00
95. 00		AMBULANCE SERVICES	0	0		0. 000000	0. 000000	95.00
96.00	1	DURABLE MEDICAL EQUIP-RENTED	0	0		0.000000	0.000000	
97. 00 98. 00	1	DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COSTS	0	0		0.000000 0.000000	0. 000000 0. 000000	
99. 00				0		0.000000	0.000000	99.00
	09910		Ö	0		0		99. 10
		I &R SERVI CES-NOT APPRVD PRGM	0	0		0		100.00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0		0		101. 00
105. 00		KIDNEY ACQUISITION	l	0		0		105. 00
106.00	10600	HEART ACQUISITION		Ö		0		106. 00
		LIVER ACQUISITION	0	0		0		107. 00
		LUNG ACQUISITION	0	0		0		108.00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION		0				109. 00 110. 00
		ISLET ACQUISITION		0		o l		111. 00
113.00	11300	INTEREST EXPENSE		· ·				113.00
		UTI LI ZATI ON REVI EW-SNF				_[114. 00
	111500	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
		HUCDI CE	\ \n	^		ΛI '		1114 00
	11600	HOSPICE Subtotal (see instructions)	0 238, 413, 438	0 266, 497, 648	504, 911, 08	0		116. 00 200. 00

Health Financial Systems LU	JTHERAN MUSCULOS	SKELETAL CENTER	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
				From 01/01/2018 To 12/31/2018	Part Date/Time Pre	nared.
				10 12/31/2010	5/30/2019 3: 4	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (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)	238, 413, 438	266, 497, 648	504, 911, 08	6		202. 00

Title XVIII

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
LANDATI ENT. DOUTLAS OFFICE COOT OFFITEDO	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT				30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				34.00
40. 00 04000 SUBPROVI DER - PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				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
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 104972			50. 00
51. 00 05100 RECOVERY ROOM	0. 041031			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0. 089173 0. 021883			54. 00 54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 948389			57.00
58. 00 05800 MRI	0. 024136			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 095189			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 029158			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 313353			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 032852			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 065640			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 118875			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 043201			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
OUTPATIENT SERVICE COST CENTERS				00.00
88. 00 08800 RURAL HEALTH CLINIC				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000			89. 00 90. 00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 499808			92.00
OTHER REIMBURSABLE COST CENTERS	0. 477000			72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98.00 09850 OTHER REIMBURSABLE COSTS	0. 000000			98. 00
99. 00 09900 CMHC				99.00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00
106. 00 10600 HEART ACQUISITION				106. 00
107. 00 10700 LI VER ACQUI SI TI ON				107. 00
108. 00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111.00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 I NTEREST EXPENSE				113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00
(222 : 1100 : 300 : 310)	1			1232.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
					From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/30/2019 3:4	pared:
			Ti tl	e XIX	Hospi tal	Cost	o piii
					Costs		
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
	LADATI FAIT DOUTLAGE CERVI OF COCT OFFITERS	1.00	2. 00	3.00	4. 00	5. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 216, 900		6, 216, 90	ol ol	6, 216, 900	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0, 210, 700		0, 210, 70		0, 210, 300	31.00
32. 00	03200 CORONARY CARE UNIT	0			o o	0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0			0 0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0				0	41. 00
43.00	04300 NURSERY	o			o o	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0 0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	ı o		1	<u> </u>		70.00
	05000 OPERATING ROOM	19, 788, 883		19, 788, 88		19, 788, 883	
51.00	05100 RECOVERY ROOM	1, 228, 072		1, 228, 07		1, 228, 072	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0			0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	837, 741		837, 74		837, 741	ı
54. 01	03630 ULTRA SOUND	6, 990		6, 99		6, 990	
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	7, 093		7, 09	3 0	0 7, 093	
58. 00	05800 MRI	2, 904		2, 90		2, 904	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	598, 554		598, 55	4 0	598, 554	
60. 01 61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	Ö			o o	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 24, 992		24, 99	0 0 2	24 002	
65. 00 66. 00	06600 PHYSI CAL THERAPY	5, 473, 084	C	5, 473, 08		24, 992 5, 473, 084	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	C)	o o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C)	0 0	0	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	31, 344		31, 34	0 0	31, 344 0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 010, 244		2, 010, 24		2, 010, 244	ł
	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 498, 956		18, 498, 95		18, 498, 956	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 286, 615		2, 286, 61		2, 286, 615	
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0			0 0 0 0	0	ı
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u>o_l </u>		70.00
	08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			0 0	0	
91. 00	09100 EMERGENCY	0				0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	579, 913		579, 91	3	579, 913	
04.00	OTHER REIMBURSABLE COST CENTERS				ما		
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0			0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	o o			o o	0	1
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	
	O9850 OTHER REIMBURSABLE COSTS O9900 CMHC	0			0 0	0	
	09910 CORF	0			0	0	
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0			o l	0	100.00
101.00	10100 HOME HEALTH AGENCY	0			0	0	101. 00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	l ol			ol I	0	105. 00
	10600 HEART ACQUISITION	o o			o I		106. 00
	10700 LIVER ACQUISITION	0			0		107. 00
	10800 LUNG ACQUISITION	0			0		108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION				0		109. 00 110. 00
	11100 SLET ACQUISITION				ō		111.00
113.00	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)						114. 00 115. 00
	111600 HOSPICE	0			o I		116. 00
200.00		57, 592, 285	C	57, 592, 28	5 0	57, 592, 285	

Health Fin	ancial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	₹	In Lieu of Form CMS-2552-10		
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2018	Worksheet C Part I	
					To 12/31/2018		pared: 8 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	
201.00	Less Observation Beds	579, 913		579, 91	3	579, 913	201. 00
202. 00	Total (see instructions)	57, 012, 372	0	57, 012, 37	2 0	57, 012, 372	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/30/2019 3:48 pm Health Financial Systems

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

					5/30/2019 3:4	8 pm
			e XIX	Hospi tal	Cost	
		Charges	T		TEEDA	
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	10, 725, 069		10, 725, 069			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		10, 720, 00			31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT				Í		33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT				()		34.00
40. 00 04000 SUBPROVI DER - 1 PF				()		40.00
41. 00 04100 SUBPROVI DER - RF				Í		41.00
43. 00 04300 NURSERY				()		43.00
44. 00 04400 SKI LLED NURSING FACILITY						1
45.00 04500 NURSING FACILITY						44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE						46. 00
ANCI LLARY SERVI CE COST CENTERS	l d)		46.00
50. 00 05000 OPERATING ROOM	70, 802, 337	117, 713, 708	188, 516, 045	0. 104972	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	11, 406, 565	18, 523, 608		1	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	10, 323, 000	29, 930, 173		0. 000000	
53. 00 05300 ANESTHESI OLOGY		0			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 360, 963	8, 033, 548	1		0. 000000	
54. 00 03400 RADI OLOGI - DI AGNOSTI C 54. 01 03630 ULTRA SOUND	294, 394	25, 027	319, 421		0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	274, 374	25, 027	317, 42		0. 000000	
56. 00 05600 RADI 01 SOTOPE		0		0.000000	0. 000000	
	7 470	0	7 470		0. 000000	
	7, 479	0	7, 479			
58. 00 05800 MRI	120, 317	0	120, 317		0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1 000 (50	(200 053	0.00000	0.000000	
60. 00 06000 LABORATORY	4, 388, 393	1, 899, 659	6, 288, 052		0.000000	
60. 01 06001 BLOOD LABORATORY	0	0	(0.000000	0.000000	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0.000000	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0.000000	0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	(0.000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	668, 107	189, 002	· ·		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	1, 698, 204	15, 767, 981	17, 466, 185		0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0	(0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	233, 007	721, 103	954, 110		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0. 000000	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 066, 385	20, 558, 705			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	105, 245, 425	50, 371, 640			0. 000000	1
73.00 07300 DRUGS CHARGED TO PATIENTS	21, 357, 156	31, 573, 033	52, 930, 189		0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0	(0. 000000	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	(0.000000	0. 000000	75. 00
OUTPATIENT SERVICE COST CENTERS			T -			
88.00 08800 RURAL HEALTH CLINIC	0	0	(0. 000000	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0. 000000	
90. 00 09000 CLI NI C	0	0	(0. 000000	
91. 00 09100 EMERGENCY	0	0	(0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	39, 637	1, 120, 634	1, 160, 271	0. 499808	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS				0.00000	0.00000	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0			0.000000	
95. 00 09500 AMBULANCE SERVI CES	0	0			0.000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0.000000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	(0. 000000	1
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	[0. 000000	0. 000000	
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			_			ļ
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105. 00
106. 00 10600 HEART ACQUI SI TI ON	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)	(109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	((110.00
111. 00 11100 I SLET ACQUI SI TI ON		0		ן		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	(<u> </u>		115. 00
116. 00 11600 HOSPI CE	0	0	(ן		116. 00
200.00 Subtotal (see instructions)	238, 413, 438	266, 497, 648	504, 911, 086			200.00
201.00 Less Observation Beds						201. 00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu					u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Peri od:	Worksheet C	
				From 01/01/2018 To 12/31/2018	Part Date/Time Pre	nared.
				10 12/31/2010	5/30/2019 3: 4	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	238, 413, 438	266, 497, 648	504, 911, 08	6		202. 00

In Lieu of Form CMS-2552-10
Worksheet C
Part I
B1/2018 Date/Time Prepared:
5/30/2019 3:48 pm Peri od: From 01/01/2018 To 12/31/2018

		Title XIX	Hospi tal	5/30/2019 3: 48 Cost	s piii
Cost Center Description	PPS Inpatient	THE MA	1103pr tur	0031	
·	Ratio				
	11. 00				
30. 00 O3000 ADULTS & PEDIATRICS					30. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - PF					40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY					41. 00 43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY					44. 00
45. 00 04500 NURSING FACILITY					45. 00
46.00 O4600 OTHER LONG TERM CARE					46.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51. 00 05100 RECOVERY ROOM	0.000000				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000 0. 000000				52. 00 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	0. 000000				55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000				56. 00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0.000000				57. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000 0. 000000				58. 00 59. 00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 000000				64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENT	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000				72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
OUTPAȚI ENT SERVI CE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0. 000000 0. 000000				90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 O9400 HOME PROGRAM DIALYSIS	0. 000000				94.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0.000000				96. 00 97. 00
98.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09850 OTHER REIMBURSABLE COSTS	0. 000000 0. 000000				98.00
99. 00 09900 CMHC	0.00000				99. 00
99. 10 09910 CORF					99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					100. 00
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					105 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION					105. 00 106. 00
107. 00 10700 LIVER ACQUISITION					100.00
108. 00 10800 LUNG ACQUISITION					108. 00
109.00 10900 PANCREAS ACQUISITION					109. 00
110.00 11000 INTESTINAL ACQUISITION					110. 00
111. 00 11100 SLET ACQUI SI TI ON					111. 00
113. 00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00 115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

		SKELETAL CENTE			u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (COSTS	Provi der C	CN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part I Date/Time Pre 5/30/2019 3:4	
		Ti tl e	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
·	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos	t		
	Part II, col.		(col. 1 - co	1.		
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	725, 142	C	725, 1	42 5, 982	121. 22	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31. 00
32. 00 CORONARY CARE UNIT	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	34.00
40. 00 SUBPROVI DER - I PF	0	C		0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	0	Ċ	ol .	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	
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	725, 142		725, 1	42 5, 982		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 811	219, 529				30.00
31.00 INTENSIVE CARE UNIT	0	C				31.00
32. 00 CORONARY CARE UNIT	0	C				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	C				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	C				34.00
40. 00 SUBPROVI DER - I PF	0	C)			40.00
41. 00 SUBPROVI DER - I RF	0	C				41.00
43. 00 NURSERY	0	Ċ				43.00
44.00 SKILLED NURSING FACILITY	0	Ċ	ol			44. 00
45. 00 NURSING FACILITY	0	Ċ	1			45. 00
						1

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

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0168	Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018	Part II	narod:
				10 12/31/2010	Date/Time Pre 5/30/2019 3:4	8 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2. 00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	1, 668, 123	188, 516, 045	0. 00884	19 29, 634, 449	262, 235	50.00
51. 00 05100 RECOVERY ROOM	443, 797	29, 930, 173			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	i		Ō	
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		Ō	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	116, 625	9, 394, 511			13, 500	1
54. 01 03630 ULTRA SOUND	14	319, 421	1		0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	ı		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	ı		0	56. 00
57. 00 05700 CT SCAN	14	7, 479			0	57. 00
58. 00 05800 MRI	5	120, 317		12 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59. 00
60. 00 06000 LABORATORY	2, 958	6, 288, 052	0.00047	70 1, 591, 437	748	60.00
60. 01 06001 BL00D LABORATORY	0	0	0.00000		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	0. 00000	00	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	00	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000	00	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	50	857, 109	0.00005	58 279, 217	16	65. 00
66. 00 06600 PHYSI CAL THERAPY	813, 301	17, 466, 185	1		68, 899	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000		0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	7 0.0000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	63	954, 110	1		l .	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 092	30, 625, 090	1			1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	227, 250	155, 617, 065	1		46, 161	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 775	52, 930, 189	1		431	73.00
74. 00 07400 RENAL DIALYSIS	0	0			0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	00 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1		0	89.00
90. 00 009000 CLINI C	0	0	1		0	90.00
91. 00 09100 EMERGENCY	0	0	0.00000		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	67, 641	1, 160, 271	1		2, 311	
OTHER REIMBURSABLE COST CENTERS	07,041	1, 100, 271	0.0302	70 37,037	2, 311	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			0.00000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	n	0. 00000		Ö	97. 00
98. 00 09850 OTHER REIMBURSABLE COSTS	0	Ö	1		Ö	1
200.00 Total (lines 50 through 199)	3, 367, 708	494, 186, 017	1	74, 077, 718	396, 834	
, , ,	•		•		•	•

Health Financial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	₹	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C		eri od:	Worksheet D	
				rom 01/01/2018		
			T	o 12/31/2018	Date/Time Pre	pared:
			20111		5/30/2019 3: 4	8 pm
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School			All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adj ustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	0	٦ -	1	_	-	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	C	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	ol c	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	ol o		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0			0	0	40.00
41. 00 04100 SUBPROVI DER - I RF				o o	ő	41. 00
43. 00 04300 NURSERY				0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY				0	U	44. 00
45. 00 04500 NURSING FACILITY				0		45. 00
200.00 Total (lines 30 through 199)	0	0	0	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	5, 982	0.00	1, 811	30.00
31.00 03100 INTENSIVE CARE UNIT		0	C	0.00	0	31. 00
32. 00 03200 CORONARY CARE UNIT		0	ol c	0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34.00
40. 00 04000 SUBPROVI DER - PF	0				0	40.00
41. 00 04100 SUBPROVI DER - I RF				0.00	ő	41. 00
43. 00 04300 NURSERY				0.00	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY						44. 00
45. 00 04500 NURSING FACILITY					0	
			1	0.00	Ĭ	45. 00
200.00 Total (lines 30 through 199)		0	5, 982		1,811	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
I NPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	0	l .				30. 00
31.00 03100 INTENSIVE CARE UNIT	0	1				31. 00
32. 00 03200 CORONARY CARE UNIT	0)				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0)				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - 1 PF						40.00
41. 00 04100 SUBPROVI DER - I RF						41. 00
43. 00 04300 NURSERY						43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY		1				44. 00
45. 00 04500 NURSING FACILITY		l .				45. 00
		l .				
200.00 Total (lines 30 through 199)	1	'I				200. 00

THROUGH COSTS

								5/30/2019 3: 48	3 pm
				Titl∈	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nur	sing School	Nursi na	School	Allied Health	Allied Health	
	5551 5511tol. 25551 Ft. 511	Anesthetist		st-Stepdown	lu. Si ng	0000.	Post-Stepdown	/ II / I od i iodi iii	
		Cost		djustments			Adjustments		
		1.00	A	2A	2.0	ın	3A	3. 00	
	ANCILL ADV. CEDVI CE COCT CENTEDO	1.00		ZA	2.0	10	SA	3.00	
	ANCILLARY SERVICE COST CENTERS	1							
50. 00	05000 OPERATING ROOM		"	0	1	0	0	0	50.00
51. 00	05100 RECOVERY ROOM)	C	1	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C		0	1	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	C		0	1	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C)	0	ı	0	0	0	54.00
54. 01	03630 ULTRA SOUND		ol	0	ı	0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C		ol .	0	ı	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE			0	l	0	0	0	56. 00
57. 00	05700 CT SCAN			0	1	0	0	0	57. 00
58. 00	05800 MRI		()	0		0	0	0	58. 00
			"	U	1	0	U		
59. 00	05900 CARDI AC CATHETERI ZATI ON		"	Ü	1	0	0	0	59. 00
60. 00	06000 LABORATORY	C	9	C	1	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	C)	0	1	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C)	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.)	0	ı	0	o	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	C	ol	0	ı	0	0	ol	64.00
65. 00	06500 RESPI RATORY THERAPY			0	l	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY			0	l	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		3	0]	0	0	0	67. 00
	1		3	0	1	0	0	0	
68. 00	06800 SPEECH PATHOLOGY		"	U	1	0	U	Ĭ	68. 00
69. 00	06900 ELECTROCARDI OLOGY		1	Ü	1	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C	9	C	1	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C)	0	1	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C		0	1	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C)	0		0	0	0	73.00
74.00	07400 RENAL DIALYSIS		ol	0	ı	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	C	ol	0	ı	0	0	0	75.00
70.00	OUTPATIENT SERVICE COST CENTERS		1		1		9	- J	70.00
88. 00	08800 RURAL HEALTH CLINIC		ı	0	ı	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			0	1	0	0	Ö	89. 00
			()	0	1	0	0		
90.00	09000 CLI NI C		"	U		0	U	0	90.00
91. 00	09100 EMERGENCY	C	"	Ü	1	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	C)			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS		,						
94.00	09400 HOME PROGRAM DIALYSIS	C		0	1	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES								95.00
	09600 DURABLE MEDICAL EQUIP-RENTED			0	l .	0	ol	0	96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD		ا	0	d .	0	n	0	97. 00
98. 00	09850 OTHER REI MBURSABLE COSTS		ا	n	,	n	n	0	98. 00
200.00	1			0	J	0	o		200. 00
200.00	1 10tal (Tilles 30 till bugli 177)	1	Ί	U	1	U	ı Yı	ı o	200.00

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0168	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost Cost (sum of 1, 2, 3, and Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) and 4) 4.00 5.00 7.00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 188, 516, 045 0.000000 50.00 00000000000000 0 51.00 05100 RECOVERY ROOM 29, 930, 173 0.00000051.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 9, 394, 511 0.000000 54.00 54.00 54.01 03630 ULTRA SOUND 0 319, 421 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0 0.000000 56 00 56 00 05700 CT SCAN 7, 479 57.00 0.000000 57.00 58.00 05800 MRI 120, 317 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 59.00 6, 288, 052 06000 LABORATORY 0 000000 60 00 60 00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 0000000000000 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 857, 109 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0 0.000000 17, 466, 185 66 00 67.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 954, 110 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0.000000 70 00 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 30, 625, 090 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 155, 617, 065 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 52, 930, 189 73.00 0 0.000000 73.00 0 07400 RENAL DIALYSIS 0.000000 74.00 Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 C 0 0.000000 89 00 90.00 09000 CLI NI C 0 0.000000 90.00 0 0 91.00 09100 EMERGENCY 0 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 1, 160, 271 0 0 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0.000000 95.00 09500 AMBULANCE SERVICES 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0.000000 97.00 98. 00 09850 OTHER REIMBURSABLE COSTS 0 0 0.000000 98.00

0

494, 186, 017

200.00

200.00

Total (lines 50 through 199)

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

From 01/01/2018 | Part IV To 12/31/2018 | Date/Time Prepared: THROUGH COSTS 5/30/2019 3:48 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 29, 634, 449 23, 710, 428 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 1, 087, 496 54.00 1, 151, 562 0 54.01 03630 ULTRA SOUND 0.000000 0 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 0 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 Ω 0 05700 CT SCAN 0 57.00 0.000000 C 0 57.00 58.00 05800 MRI 0.000000 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 0 59.00 1, 591, 437 06000 LABORATORY 180, 167 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 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 279, 217 15, 210 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 1, 479, 668 66.00 160, 734 0 06700 OCCUPATIONAL THERAPY 0 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 221, 204 282, 296 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.000000 3, 339, 918 1, 578, 946 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 31, 617, 076 0 8, 353, 215 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 4, 787, 616 2, 330, 409 73.00 0 74.00 07400 RENAL DIALYSIS 0 0.000000 74.00 0 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 0 89 00 89 00 Ω 0 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 0.000000 0 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 186, 515 92.00 39, 637 0 0 92.00 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 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 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 0 74, 077, 718 0 200.00

37, 949, 482

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 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/30/2019 3:4	pared: 8 nm
			Title	XVIII	Hospi tal	PPS	о рііі
			11110	Charges	поэрт саг	Costs	
	Cost Center Description	Cost to Charge PP	S Doi mburgod	Cost	Cost	PPS Services	
	cost center bescription		ervi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Hist.)	
		Part I, col. 9	11151.)	Subject To	Subject To		
		rait i, coi. 9		Ded. & Coins			
		1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0. 104972	23, 710, 428		0 0	2, 488, 931	50.00
51. 00	05100 RECOVERY ROOM	0. 104972	23, 710, 428		0 0	2, 400, 731	51.00
		l l	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		٥	ľ	52.00
53.00	05300 ANESTHESI OLOGY	0.000000	0		0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 089173	1, 151, 562		0 0	102, 688	1
54. 01	03630 ULTRA SOUND	0. 021883	0		0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57.00	05700 CT SCAN	0. 948389	0		0 0	0	57. 00
58. 00	05800 MRI	0. 024136	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. 095189	180, 167		0 0	17, 150	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60, 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	_		0	_	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	Ö	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	15, 210		0 0	443	
	1 1	1			-	l .	1
66.00	06600 PHYSI CAL THERAPY	0. 313353	160, 734		0 0	50, 366	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 032852	282, 296		0 0	9, 274	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 065640	1, 578, 946		0	103, 642	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 118875	8, 353, 215		0	992, 988	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 043201	2, 330, 409		0 5, 315	100, 676	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
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	0	90.00
91.00	09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 499808	186, 515		0 0	93, 222	1
	OTHER REIMBURSABLE COST CENTERS	27.77.7520	,				1
94.00	09400 HOME PROGRAM DI ALYSI S	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	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		98.00
200.00		0.000000	37, 949, 482		٥	2 050 200	
			31, 749, 482		0 5, 315	3, 959, 380	
201.00							201. 00
202.00	Only Charges (Line 200 Line 201)		37, 949, 482		0 5, 315	3, 959, 380	202 00
202.00	Net Charges (line 200 - line 201)	1	31, 747, 482	I	ارم على	J 3, 707, 38U	1202.00

				10 12/31/2018	Date/IIme Pre 5/30/2019 3:4	
		Title	xVIII	Hospi tal	PPS	Орш
	Cos					
Cost Center Description	Cost	Cost				
'	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	,					
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0)			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0)			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)			54. 00
54.01 03630 ULTRA SOUND	0	0)			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	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	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0)			60.00
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	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	0)			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	230				73.00
74.00 07400 RENAL DIALYSIS	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	0				89. 00
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 O9200 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					95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0)			96. 00
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)	0	230)			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	230	1			202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0168 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/30/2019 3:48 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 104972 598, 660 0 50.00 51.00 05100 RECOVERY ROOM 0.041031 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52 00 0 0 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.000000 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.089173 20, 902 0 54.00 54.01 03630 ULTRA SOUND 0.021883 0 0 54.01 0 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 05700 CT SCAN 0 57.00 0. 948389 0 0 0 57.00 05800 MRI 0.024136 0 58 00 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 06000 LABORATORY 0.095189 0 60.00 60.00 3.489 06001 BLOOD LABORATORY 0.000000 60.01 60.01 0 0 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 0.029158 0 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 313353 109, 361 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 0.032852 0 1, 670 0 69 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.065640 317, 518 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.118875 0 0 72.00 189, 199 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.043201 C 148, 397 0 73.00 07400 RENAL DIALYSIS 0.000000 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS 75.00 0.000000 75.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 0 89.00 09000 CLINIC 90.00 90.00 0.000000 0 0 0 0 09100 EMERGENCY 0 91.00 0.000000 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.499808 0 8,024 0 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 0 0 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00

0.000000

0

1, 397, 220

1, 397, 220

0

0

0

0

C

0

0

98.00

201.00

0 200. 00

0 202.00

09850 OTHER REIMBURSABLE COSTS

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

98.00

200.00

201.00

202.00

Peri od: Worksheet D From 01/01/2018 Part V To 12/31/2018 Date/Ti me Prepared: 5/30/2019 3:48 pm

					5/30/2019 3:4	18 pm
		Ti tl	e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				_
50. 00 O5000 OPERATING ROOM	0	62, 843				50.00
						51.00
51. 00 05100 RECOVERY ROOM	1 "	0				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 864				54. 00
54.01 03630 ULTRA SOUND	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI 01 SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MRI	o	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o				59.00
60. 00 06000 LABORATORY	أم	332				60.00
60. 01 06001 BLOOD LABORATORY		0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O ₁				61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0				62.00
	0	0				1
	0	- 1				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	34, 269				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	55				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20, 842				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	22, 491				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	6, 411				73. 00
74. 00 07400 RENAL DI ALYSI S	ol	0				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	o	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	0				89. 00
90. 00 09000 CLINIC		0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
l l						1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	l U	4, 010				92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
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)		153, 117				200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	O	153, 117				202. 00
						•

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/30/2019 3:4	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		5, 982	1. 00
2.00	Inpatient days (including private room days, excluding swing-			5, 982	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		5, 424	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5. 00
	reporting period			_	
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	m days) through December	31 of the cost	0	7. 00
	reporting period	3 ,			
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 811	9. 00
7. 00	newborn days)	o the rregram (exertaining	y swilling bed and	1,011	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		coom dove) ofter	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		doil days) after	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
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)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00
17.00	reporting period	23 thi ough becomber 31 c	inc cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombon 21 of	the cost	0.00	19. 00
19.00	reporting period	s till ought becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	the cost	0.00	20. 00
04 00	reporting period	`		. 01. 000	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	6, 216, 900 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	ing period (ine	o l	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
24.00	x line 18)	. 21 of the cost respont:	ng ported (Line	0	24. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (iine	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
0, 00	x line 20)				0, 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 6, 216, 900	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIE 21 IIIITIUS TITIE 20)		0, 210, 900	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) 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)	- 1111e 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00 0	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 216, 900	
200	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1, 039. 27	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 039. 27 1, 882, 118	
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 882, 118	41. 00

Heal th	Financial Systems LL	THERAN MUSCULOSKE	ELETAL CENTEI	₹	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-0168	Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018		pared:
			T: +1 a	S VVIIII	Hospi tal	5/30/2019 3: 48	8 pm
	Cost Center Description	Total	Total	Average Per		PPS Program Cost	
		Inpatient Cost In		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		, 0. 1	30 0		72.00
43.00	INTENSIVE CARE UNIT	0	C			0	
44. 00	CORONARY CARE UNIT	0	C				
45. 00 46. 00	1	0	C	1		0	
	OTHER SPECIAL CARE (SPECIFY)			0. \	50	į	47. 00
	Cost Center Description				·		
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	lino 200)			1. 00 8, 042, 668	19 00
	Total Program inpatient costs (sum of lines			ons)		9, 924, 786	1
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	n Wkst. D, sur	n of Parts I and	219, 529	50. 00
51. 00		atient ancillary	services (fr	om Wkst D s	sum of Parts II	396, 834	51. 00
01.00	and IV)	arront anorrary	33. 1. 333 (oo b,	Jam 01 1 a1 10 11	[000
52. 00	Total Program excludable cost (sum of lines					616, 363	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	ited, non-phy	sician anesth	netist, and	9, 308, 423	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					0	54. 00
55. 00							55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	et amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and targ	jet umourt (i	THE GO III HGS	11110 00)	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 roport unda	atod by the n	arkot backot		0.00	60. 00
61. 00					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		ent (see instruct	i ons)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST	(11111111111111111111111111111111111111					
64. 00		ts through Decemb	er 31 of the	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 o	ost reporting	period (See	o	65. 00
	instructions) (title XVIII only)						
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	e costs through D	ecember 31 d	of the cost re	eporting period	0	67. 00
07.00	(line 12 x line 19)	o ooo to tiii ougii b			sportring porrod		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	: 68)		0	69. 00
_ /. 00	PART III - SKILLED NURSING FACILITY, OTHER N	· · · · · · · · · · · · · · · · · · ·					
70.00	Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /U ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine serv	ice costs (line 7	'2 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient	routine service c	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	,					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	nus line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		, crimitati Oi	. (11116 /0 11111	143 TITE 11)		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		:)				84. 00 85. 00
86. 00						<u> </u>	86. 00
_	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	-				
87. 00 88. 00	3 .		ine 2)			558 1, 039. 27	87.00
	Observation bed cost (line 87 x line 88) (se		1110 2)			579, 913	1
		,					

Health Financial Systems	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/30/2019 3:4	
		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	725, 142	6, 216, 900	0. 11664	579, 913	67, 641	90.00
91.00 Nursing School cost	0	6, 216, 900	0.00000	579, 913	0	91.00
92.00 Allied health cost	0	6, 216, 900	0.00000	579, 913	0	92.00
93.00 All other Medical Education	0	6, 216, 900	0. 00000	579, 913	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od: From 01/01/2018	Worksheet D-1	
			Date/Time Pre 5/30/2019 3:4	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Ti +I o VI V	Hooni tal	5/30/2019 3: 4	8 pm
	Cost Center Description	Title XIX	Hospi tal	Cost	
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	e oveluding nowborn)		5, 982	1. 00
2.00	Inpatient days (including private room days, excluding swing-left days)			5, 982	2.00
3.00	Private room days (excluding swing-bed and observation bed day	<i>3</i> ,	vate room days,	0	3. 00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		21 of the cost	5, 424 0	4. 00 5. 00
5.00	reporting period	on days) through becember	31 Of the Cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		24 6 11		7.00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	31	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		a room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (merdaring private	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye			0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 21 of th	an cost	0.00	20. 00
20.00	reporting period	s al tel becember 31 of th	ie cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions			6, 216, 900	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
20.00	x line 18)	or or the dost reporting	g perrou (rriie o	· ·	20.00
24. 00] 3 11 31	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	or the cost reporting	perrou (Trile 8	O	25.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 216, 900	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General innatient routine service charges (excluding swing-ber	d and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	in ges)	0	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 216, 900	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 039. 27	
39. 00	Program general inpatient routine service cost (line 9 x line	•		32, 217	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 32, 217	40. 00 41. 00
. 1. 00	1.2.2 og. am gonor ar imparione routino sorvice cost (Title 37		ı	52, 217	

	Financial Systems LU FATION OF INPATIENT OPERATING COST	JTHERAN MUSCULOS		EK CCN: 15-0168	Peri od:	worksheet D-	
				10 0100	From 01/01/2018		
					To 12/31/2018	Date/Time Pr 5/30/2019 3:	
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent costi	праттепт рау	col . 2)	7	4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.	00 0		42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l		0 0.	00 0	1 (43.00
44. 00					00 0		44.00
45. 00		0			00 0		45.00
46. 00		0		0.	00 0	(46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			61, 47	4 48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		93, 69	1 49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sorvices (fro	om Wket D su	m of Darts L and	Ι ,	50.00
30. 00		attent routine	services (iic	JIII WKST. D, SU	iii or rarts r and	`	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II		51.00
52.00	and IV)	50 and 51)					52.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-nh	nysician anest	hetist and		52. 00 53. 00
_ 5. 50	medical education costs (line 49 minus line		non pi	., s. s. an anost		<u> </u>] 55. 50
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge						54. 00 55. 00
56. 00							56.00
57. 00	,	ing cost and ta	rget amount ((line 56 minus	line 53)	l .	57.00
58. 00	Bonus payment (see instructions)						58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61. 00							61.00
	which operating costs (line 53) are less tha		s (lines 54 x	(60), or 1% o	f the target		
52 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts through Dece	mber 31 of th	ne cost report	ing period (See	(64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	a period (See		65.00
	instructions) (title XVIII only)			•			
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	(66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period		67.00
37.00	(line 12 x line 19)	c costs till ough	becomber or	or the cost r	epor tring period	·	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period		68. 00
40 NN	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (line 67 ± lir	ne 68)			69.00
37. 00	PART III - SKILLED NURSING FACILITY, OTHER N					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	51 07.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37)		70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v l	ine 35)			72. 00
74. 00							74.00
75. 00		•		*	Part II, column		75. 00
7/ 00	26, line 45)	2)					7, 0
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00
78. 00	,						78. 00
79. 00	1 33 3						79. 0
	Total Program routine service costs for comp		ost limitatio	on (line 78 mi	nus line 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 0
33. 00	Reasonable inpatient routine service costs (83. 0
84. 00	Program inpatient ancillary services (see in	structions)					84. 0
85.00	1 3 1						85. 0
36. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86. 00
37. 00	Total observation bed days (see instructions					558	87.00
	, .	•	line 2)			1, 039. 2	
88. 00	Observation bed cost (line 87 x line 88) (se	•	•			579, 91:	. 1

Health Financial Systems	JTHERAN 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 01/01/2018 To 12/31/2018	Date/Time Prep 5/30/2019 3:4	
		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	725, 142	6, 216, 900	0. 11664	0 579, 913	67, 641	90.00
91.00 Nursing School cost	0	6, 216, 900	0.00000	579, 913	0	91.00
92.00 Allied health cost	0	6, 216, 900	0.00000	579, 913	0	92.00
93.00 All other Medical Education	0	6, 216, 900	0. 00000	579, 913	0	93. 00

Health Financial Systems	LUTHERAN MUSCULOSKELE	TAL CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	Provider CC		Peri od: From 01/01/2018	Worksheet D-3	
				To 12/31/2018	Date/Time Prep 5/30/2019 3:48	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	

				To 12/31/2018	Date/Time Pre 5/30/2019 3:4	
		Ti tl e	e XVIII	Hospi tal	PPS	о рііі
	Cost Center Description		Ratio of Cos		Inpatient	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			0.055.540	ı	00.00
	03000 ADULTS & PEDI ATRI CS			3, 055, 512		30.00
	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT			0		31. 00 32. 00
	03300 BURN INTENSIVE CARE UNIT					33. 00
	03400 SURGICAL INTENSIVE CARE UNIT					34. 00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER – I RF			0		41. 00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS		1	-		
	05000 OPERATING ROOM		0. 10497	2 29, 634, 449	3, 110, 787	50. 00
51. 00	05100 RECOVERY ROOM		0. 04103	1 0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
	05300 ANESTHESI OLOGY		0.00000		0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 08917			54.00
	03630 ULTRA SOUND		0. 02188		1	54. 01
	05500 RADI OLOGY-THERAPEUTI C		0.00000		1	55. 00
	05600 RADI OI SOTOPE		0.00000		0	56.00
	05700 CT SCAN 05800 MRI		0. 94838		0	57.00
	05800 MRT 05900 CARDI AC CATHETERI ZATI ON		0. 02413 0. 00000		1	58. 00 59. 00
60. 00	06000 LABORATORY		0. 09518			60.00
	06001 BLOOD LABORATORY		0.00000			60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000			61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		1	63. 00
	06400 INTRAVENOUS THERAPY		0.00000		0	64.00
	06500 RESPI RATORY THERAPY		0. 02915		8, 141	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 31335	3 1, 479, 668	463, 658	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0.00000	0	0	68. 00
	06900 ELECTROCARDI OLOGY		0. 03285		7, 267	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0.00000		1	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.06564			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 11887			72.00
	07300 DRUGS CHARGED TO PATIENTS		0.04320			73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0.00000		-	74. 00 75. 00
	OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	75.00
	08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
	09000 CLINIC		0.00000		1	90.00
	09100 EMERGENCY		0.00000		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 49980		19, 811	ı
	OTHER REIMBURSABLE COST CENTERS			<u> </u>	·	
94. 00	09400 HOME PROGRAM DIALYSIS		0.00000	0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	96. 00
	09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		1	97. 00
	09850 OTHER REIMBURSABLE COSTS		0.00000		_	98. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		74, 077, 718		
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)		74 077 710		201. 00
202. 00	Net charges (line 200 minus line 201)		I	74, 077, 718	I	202. 00

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

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm Title XIX Hospi tal Cost Inpati ent Cost Center Description Ratio of Cost Inpati ent To Charges Program Program Costs (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 57, 015 03000 ADULTS & PEDIATRICS 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31 00 32.00 03200 CORONARY CARE UNIT 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVIDER - IPF 0 40.00 40.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.104972 252, 530 26, 509 50.00 51.00 05100 RECOVERY ROOM 0.041031 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.089173 10, 206 910 54.00 03630 ULTRA SOUND 0.021883 54.01 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0.000000 55 00 0 0 55 00 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.948389 0 0 57.00 05800 MRI 58.00 0.024136 0 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 0.000000 59 00 0 0 60.00 06000 LABORATORY 0.095189 25, 061 2, 386 60.00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 0 61 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 o 0 64.00 06500 RESPIRATORY THERAPY 65 00 0.029158 65 00 0 06600 PHYSI CAL THERAPY 66.00 0.313353 24, 175 7, 575 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0.032852 69 00 4,626 152 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 Ω 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 597 71.00 0.065640 630 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.118875 171, 734 20.415 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.043201 67.070 2.897 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 90.00 09000 CLI NI C 0.000000 0 0 90.00 09100 EMERGENCY 0 91.00 91.00 0.000000 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.499808 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0 0 97.00 09850 OTHER REIMBURSABLE COSTS 98.00 0.000000 0 98.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 564, 999 61, 474 200. 00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 Net charges (line 200 minus line 201) 202.00 564, 999 202.00

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 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Ti me Prepared: 5/30/2019 3:48 pm

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00			T: +1 a V/////	Heeni tel	5/30/2019 3: 4	8 pm
Next A - IMPATIBNE HOSPITAL SERVICES WORE IPPS			Title XVIII	Hospi tal	PPS	
1.00 DRC Amounts other than outlier Payments 0 0 0 1.00 DRC Amounts other than outlier payments for discharges occurring prior to October 1 (see 5,832,463 1.01 1.02 Instructions) 1.02 Instructions) 1.03					1. 00	
DNK amounts other than outlier payments for discharges occurring on or after October 1 (see 2, 365,738 1.02 DNK amounts other than outlier payments for discharges occurring on or after October 1 (see 2, 365,738 1.02 1.03 UNK for Frederial spacel'fic operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 UNK for Frederial spacel'fic operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 UNK for Frederial spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial spacel'fic operating payments for discharges occurring on or after 0 1.04 UNK for Frederial spacel'fic operating payments for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payments for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payments for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payments for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring on or after 0 1.04 UNK for Frederial Spacel'fic operating payment for discharges occurring payment for discharges occurring payment for discharges occurring payment for discharges occurring payment for discharges oc	4 00			1	-	4 00
DRC amounts other than outlier payment for discharges occurring on or after October 1 (see 2,365,738 1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				
1.03 1.08	1. 02	DRG amounts other than outlier payments for discharges occurrin	ng on or after October	l (see	2, 365, 738	1. 02
1.04 0x10per 1 (see instructions) 3.341 2.00 0x10per 2.	1. 03	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
2.00 Outlier payments for discharges (see instructions) 3.341 2.00	1. 04	DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring o	on or after	0	1. 04
Managed Care Simulated Payments 6,772,632 3.00		Outlier payments for discharges. (see instructions)				
Bert days available divided by number of days in the cost reporting period (see instructions) 37.47 4.00		, , ,	ons)		- 1	
Indirect Medical Education Adjustment						
or before 12/31/1996. (see Instructions) or before 12/31/1996. (see Instructions) or before 12/31/1996. (see Instructions) 7.00 MM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 7.01 ACA \$5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see Instructions) 8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 9.0 Sum of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see		Indirect Medical Education Adjustment		,		
new programs in accordance with 42 CER 413.79(e) 0.00 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CER \$412.105(f)(1)(iv)(B)(2) if the cost cost report straddle sully 1, 2011 then see instructions 0.00 7.01 0.00		or before 12/31/1996. (see instructions)				
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the cost report straddles July 1, 2011 then see instructions.		new programs in accordance with 42 CFR 413.79(e)				
Agi ustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under 4				
The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.	8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79			0. 00	8. 00
Section The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
Instructions 1.00 TE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital			0. 00	8. 02
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 15.00 1	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see			0. 00	9. 00
13.00 Total allowable FTE count for the prior year. 0.00 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 14.00 14.00 14.00 15.00			nt year from your record	ds		
14.00		· · · · · · · · · · · · · · · · · · ·				
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18.00 18.00 20		Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,		
17. 00	15. 00				0.00	15. 00
18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 00 IME payment adjustment (see instructions) 0.22. 00 1 IME payment adjustment - Managed Care (see instructions) 0.22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23. 00 (f)(1)(iv)(c). 0.1 0.00 24. 00 24. 00 25. 00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 26. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 26. 00 28. 01 IME add-on adjustment amount see instructions 0.000000 27. 00 28. 01 IME add-on adjustment a						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 1 IME payment adjustment - Managed Care (see instructions) 0.00 22.01 1 Iminoret Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 23.00 (f)(1)(iv)(C). 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 0.000000 27.00 28.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.000000 27.00 0.00 28.01 29.01 Total IME payment (sum of lines 22 and 28) 0.29.00 <			ire			
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 21.00 0.000000 22.00 0.000000 22.00 0.000000 22.00 0.000000 22.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000						
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 25.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 25.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 0.000000 0.0000000 0.0000000 29.01 0.0000000 0.0000000 0.0000000 29.01 0.00000000000000000000000000000000		, ,				
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 IME payments adjustment factor. (see instructions) 26.00 IME payments adjustment factor. (see instructions) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions) 30.00 IME payment adjustment days (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions)						
22. 01 IME payment adjustment - Managed Care (see instructions)						
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	22. 01				0	22. 01
(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) 1f the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Sum of lines 30 and 31	22.00			D 412 10E	0.00	22.00
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Image of the sum of lines 22.01 and 28.01) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Image of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Image of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 30.00 Image of line 24 (see instructions) 30.00 Image of line 25 by line 4) 30.00 Image of li	23.00		it cap siots under 42 or	K 412. 105	0.00	23.00
instructions	24.00				0.00	24. 00
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 29.01 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.85 30.00 31.00 Percentage of Medicaid patient days (see instructions) 0.00 31.00 32.00 Sum of lines 30 and 31 1.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 0.00 33.00	25. 00		ower of line 23 or line	24 (see	0. 00	25. 00
27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 0.29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.00 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.85 30.00 31.00 Percentage of Medicaid patient days (see instructions) 0.00 31.00 32.00 Sum of lines 30 and 31 1.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 0.00 33.00	26 00				0.000000	26 00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions)						
28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 28.01 29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 70.01 Disproportionate Share Adjustment 0 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.85 30.00 31.00 Percentage of Medicaid patient days (see instructions) 0.00 31.00 32.00 Sum of lines 30 and 31 1.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 0.00 33.00						
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.85 30.00 31.00 Percentage of Medicaid patient days (see instructions) 0.00 31.00 Sum of lines 30 and 31 1.85 32.00 Allowable disproportionate share percentage (see instructions) 0.00 33.00		,				
29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Percentage of Medicaid patient days (see instructions) 33.00 Percentage of Medicaid patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Percentage of Medicaid patient days (see instructions)						
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 1.85 30.00 31.00 32.00 31.00 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions)		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 0.00 31.00 1.85 32.00 0.00 33.00	30. 00		ient days (see instruct	tions)	1. 85	30. 00
32.00 Sum of lines 30 and 31 1.85 32.00 33.00 Allowable disproportionate share percentage (see instructions) 0.00 33.00			J (1111 1111 1111 1111 1111 1111 1111 1	´		
	32.00	. , , , , , , , , , , , , , , , , , , ,				
34.00 Disproportionate share adjustment (see instructions) 0 34.00						
	34. 00	Disproportionate share adjustment (see instructions)		l	0	34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2019 3: 48 PPS	8 pm
		THE AVIII	Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Adjustment			_	
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	,	ter zero on this line) (se		0. 000000000	1
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment al Total uncompensated care (sum of columns 1 and 2 on line 35	•	0	0	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	g discharges for MS-DRGs	0		40. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	S-DRGs 652, 682, 683, 684	0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	d by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instruction	•	0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41. 01)	9, 201, 542		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	9, 201, 342		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L, Pt. I.	•		9, 201, 542 739, 131	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. 1)			737, 131	ı
52.00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 00 54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.00
56. 00	Cost of physicians' services in a teaching hospital (see in			0	1
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		0 040 (73	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			9, 940, 673 21, 928	
61. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		9, 918, 745	
62.00	Deductibles billed to program beneficiaries	,		874, 996	
63.00				0	
	Allowable bad debts (see instructions)			12, 547	
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in:	etructions)		3, 462	65. 00 66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		9, 051, 905	
68. 00	Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (s	ee instructions)	0	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instruction	s)	0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration		instructions)	0	70. 50 70. 87
70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in:	structions)			70.89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
70 01	HSP bonus payment HRR adjustment amount (see instructions)			0	-
70. 91	Illundlad Madal 1 discount amount (acc instructions)			0	70. 92
70. 92	·				70 00
	HVBP payment adjustment amount (see instructions)			0	

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTE	-R	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		CCN: 15-0168	Peri od: From 01/01/2018	Worksheet E	pared:
	Ti tI	e XVIII	Hospi tal	PPS	
		FFY	['] (уууу)	Amount	
			0	1. 00	
70.07	() (E ;)		0	0	70.07

		T	o 12/31/2018	Date/Time Pre 5/30/2019 3:4	
	Title	xVIII	Hospi tal	PPS	
		FFY (уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
the corresponding federal year for the period ending on or aft 70.98 Low Volume Payment-3	.ei 10/1)			0	70. 98
70.99 HAC adjustment amount (see instructions)				99, 407	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			8, 952, 498	
71.01 Sequestration adjustment (see instructions)				179, 050	1
71.02 Demonstration payment adjustment amount after sequestration				0 7/5 45/	71. 02
72.00 Interim payments				8, 765, 456	ı
73.00 Tentative settlement (for contractor use only) 74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02) 72 and			0 7, 992	73.00
74. 00 barance due provider/program (11the 71 millios 11thes 71. 01, 71. 02	., 72, and			1,772	74.00
75.00 Protested amounts (nonallowable cost report items) in accordar CMS Pub. 15-2, chapter 1, §115.2	nce with			156, 703	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		'	,		
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00 Operating outlier reconciliation adjustment amount (see instru				0	92. 00
93.00 Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00 The rate used to calculate the time value of money (see instru	icti ons)			0.00	1
95.00 Time value of money for operating expenses (see instructions) 96.00 Time value of money for capital related expenses (see instructions)	i one)			0	
70.00 Trille varue or money for capital related expenses (see fristruct	.1 0113)		Prior to 10/1		70.00
			1. 00	2.00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	1
102.00 HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.00
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructions)		uctmont	l 0	0	104. 00
Rural Community Hospital Demonstration Project (§410A Demonstr 200.00 Is this the first year of the current 5-year demonstration per	ation) Auju	ha 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.	rod dilder t	THE ZIST			200.00
Cost Reimbursement			<u> </u>		
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
202.00 Medicare discharges (see instructions)					202. 00
203.00 Case-mix adjustment factor (see instructions)					203. 00
Computation of Demonstration Target Amount Limitation (N/A in	first year	of the current	5-year demonst	rati on	
peri od)					004.00
204.00 Medicare target amount					204. 00 205. 00
205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
Adjustment to Medicare Part A Inpatient Reimbursement]200.00
207. 00 Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
208. 00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)					209. 00
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	211)				212. 00
213. 00 Low-volume adjustment (see instructions)		.h			213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS ar (line 212 minus line 213) (see instructions)	iu cost reim	wursement)			218. 00
(1110 212 minus Tine 210) (See Thati detrois)			ı I		I

					o 12/31/2018	Date/Time Prep 5/30/2019 3:48	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1. 00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	6, 832, 463	6, 832, 463		6, 832, 463	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 365, 738		2, 365, 738	2, 365, 738	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	(O	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	3, 341	3, 341	0	3, 341	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	6, 772, 632	5, 141, 188	0 3 1, 631, 444	6, 772, 632	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0.000000	0.00000		5. 00
5.00	(see instructions)	21.00	0.000000	0.000000	0.00000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	(0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	(0	0	6. 01
7.00	Indirect Medical Education Adjustment for the						7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000				7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0	(0	0	8. 00 8. 01
	care (see instructions)		0				
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	(0	9. 00 9. 01
7. 01	lines 6.01 and 8.01)	29.01	0		,		7. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0000	0.0000	0.0000		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	0]	11. 00
11. 01	Uncompensated care payments	36.00	0	() 0	0	11. 01
12. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46.00	di scharges 0	() 0	0	12. 00
12.00	instructions)	40.00	0		,	ا	12.00
13.00	Subtotal (see instructions)	47.00	9, 201, 542	6, 835, 804	2, 365, 738	9, 201, 542	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0	(0	0	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	9, 201, 542	6, 835, 804	2, 365, 738	9, 201, 542	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	739, 131	549, 107	190, 024	739, 131	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	(0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(0	0	18. 00
19. 00	SUBTOTAL			7, 384, 911	2, 555, 762	9, 940, 673	19. 00

Heal th	Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	?	In Li€	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/30/2019 3:4	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	739, 131	549, 10	7 190, 024	739, 131	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0		0 0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
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 (see instructions)	10.00	0.0000	0.000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	739, 131	549, 10	7 190, 024	739, 131	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. 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	0		0 0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4.00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		73, 84	9 25, 558	99, 407	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CE	NTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	r CCN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/30/2019 3:48 pm

		10 12/31/2016	5/30/2019 3:4	
		Title XVIII Hospital	PPS	o piii
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		230	1
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)	3, 959, 380	1
3.00	OPPS payments		4, 406, 194	1
4.00	Outlier payment (see instructions)		6, 089	•
4. 01 5. 00	Outlier reconciliation amount (see instructions)	ations)	0.000	
6. 00	Enter the hospital specific payment to cost ratio (see instruction 2 times line 5	Ctrons)	0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	•
8. 00	Transitional corridor payment (see instructions)		0.00	•
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200	0	•
10.00	Organ acqui si ti ons		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		230	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges		T	
12.00	Ancillary service charges	(0)		12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges		5, 315	14. 00
15. 00	Aggregate amount actually collected from patients liable for	navment for services on a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		Ö	
	had such payment been made in accordance with 42 CFR §413.13(e	. ,		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	•	0.000000	17. 00
18. 00	Total customary charges (see instructions)		5, 315	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds line 11) (see	5, 085	19. 00
	instructions)	1011		
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)		230	21. 00
22. 00	Interns and residents (see instructions)		0	ı
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	ł
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,	4, 412, 283	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	·	13, 686	
26. 00	Deductibles and Coinsurance amounts relating to amount on line		785, 271	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22 and 23] (see	3, 613, 556	27. 00
20 00	instructions) Direct graduate modical education payments (from Wket E 4 Li	no EO)	0	28. 00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	The 50)	0	
30.00	Subtotal (sum of lines 27 through 29)		3, 613, 556	
31. 00	Pri mary payer payments		166	ı
32.00	Subtotal (line 30 minus line 31)		3, 613, 390	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)		0	
34. 00	Allowable bad debts (see instructions)		82, 808	1
35. 00	Adjusted reimbursable bad debts (see instructions)		53, 825	1
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)	67, 341 3, 667, 215	
38. 00	MSP-LCC reconciliation amount from PS&R		3,007,213	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		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, 667, 215	
40. 01	Sequestration adjustment (see instructions)	73, 344		
40. 02	Demonstration payment adjustment amount after sequestration	0 3, 540, 989		
41. 00 42. 00				1
43. 00	Balance due provider/program (see instructions)		0 52, 882	•
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2 chanter 1	0	
11.00	§115. 2	one rab. To 2, chapter 1,		00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)		0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	1
92. 00	The rate used to calculate the Time Value of Money		0.00	
93.00	Time Value of Money (see instructions)		0	1
94.00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems LUTHERA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/30/2019 3: 48 pm Provider CCN: 15-0168

					5/30/2019 3: 48	3 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		8, 765, 45	6	3, 540, 989	1. 00
2.00	Interim payments payable on individual bills, either			O	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			O	0	3. 01
3.02				O	0	3. 02
3.03				0	0	3. 03
3.04				O	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		'	O	0	3. 99
4 00	3. 50-3. 98)		0.7/5.45	,	0.540.000	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 765, 45	D	3, 540, 989	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5.02				0	o	5. 02
5.03				O	0	5. 03
	Provider to Program			·		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				O	0	5. 51
5.52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(O	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		7, 99.		52, 882	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		8, 773, 44		3, 593, 871	7. 00
				Contractor	NPR Date	
		,	`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	8. 00
0.00	Name of Contractor				l l	0.00

Heal th	Financial Systems LUTHERAN MUSCULOSK	ELETAL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			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	3-12			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 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified 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	(1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	O Delegan due provider (Line 9 (on Line 10) minus Line 20 and Line 21) (one instructions)				

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 MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2019 3:48 pm

			To 12/31/2018	Date/Time Pre 5/30/2019 3:4	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		93, 691		1. 00
2.00	Medical and other services			153, 117	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		93, 691	153, 117	4. 00
5.00	Inpatient primary payer payments		0	_	5. 00
6.00	Outpatient primary payer payments		00 (01	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		93, 691	153, 117	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges Routine service charges				8.00
9.00	Ancillary service charges		564, 999	1, 397, 220	
10. 00	Organ acquisition charges, net of revenue		304, 777	1, 377, 220	10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		564, 999	1, 397, 220	1
12.00	CUSTOMARY CHARGES		001,777	1, 077, 220	12.00
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for p	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	1
16. 00	Total customary charges (see instructions)		564, 999	1, 397, 220	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	471, 308	1, 244, 103	17. 00
	line 4) (see instructions)		_	_	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00 20. 00	Interns and Residents (see instructions)	ations)	0	0	19. 00 20. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions of covered services (enter the lesser of line 4 or line 16)		93, 691	-	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			153, 117	21.00
22. 00	Other than outlier payments	mipreted for FF3 provide	0	0	22. 00
	Outlier payments			0	
24. 00	Program capital payments			· ·	24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		o	0	1
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		93, 691	153, 117	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	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)		93, 691	153, 117	31. 00
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00			0	0	34.00
35. 00			0	450 447	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		93, 691	153, 117	36.00
37. 00 38. 00			-93, 691	-153, 117	•
			0	0	39.00
40. 00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments			0	1
41.00	Balance due provider/program (line 40 minus line 41)			0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2		0	
10.00	chapter 1, §115.2	, til 5m5 l db 15 2,		O	10.00
	, , , , , , , , , , , , , , , , , , ,		'		'

Health Financial Systems

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

Provider CCN: 15-0168

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/30/2019 3:48 pm

	·	General Fund	Speci fi c	Endowment Fund	Plant Fund	8 piii
		deneral runa	Purpose Fund	Endowner Tana	Traire rana	
		1.00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	004 004	Ι	ا		1 4 00
1. 00 2. 00	Cash on hand in banks Temporary investments	-281, 801	0	_	0	1. 00 2. 00
3. 00	Notes receivable	0	0	=	0	3.00
4. 00	Accounts receivable	23, 189, 899	_	o	0	4. 00
5.00	Other recei vable	0	0	o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-3, 320, 156	0	0	0	6. 00
7. 00	Inventory	1, 557, 288		0	0	7. 00
8.00	Prepai d expenses	198, 368		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	81, 193	0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	21, 424, 791	0		0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12. 00
13.00	Land improvements	26, 765		_	0	13. 00
14.00	Accumulated depreciation	-13, 561	0	0	0	14.00
15. 00	Buildings Accumulated depreciation	27, 748		0	0	15.00
16. 00 17. 00	Leasehold improvements	-3, 875 4, 017, 702		=	0	16. 00 17. 00
18. 00	Accumulated depreciation	-482, 532		=	0	18. 00
19. 00	Fi xed equipment	660, 782		Ö	0	19. 00
20.00	Accumulated depreciation	-264, 061	0	o	0	20. 00
21. 00	Automobiles and trucks	28, 303		0	0	21. 00
22. 00	Accumul ated depreciation	-23, 914		0	0	22. 00
23. 00	Maj or movable equipment	12, 954, 932		0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-6, 864, 224 2, 033, 464		0	0	24. 00 25. 00
26. 00	Accumulated depreciation	-1, 428, 165		0	0	26.00
27. 00	HIT designated Assets	1, 420, 109	0	Ö	0	27. 00
28. 00	Accumulated depreciation	0	Ō	Ö	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	10, 669, 364	0	0	0	30. 00
04.00	OTHER ASSETS	_	1			1 04 00
31.00	Investments	0	0		0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers		0	=	0	32. 00 33. 00
34. 00	Other assets	694, 093			0	34.00
35. 00	Total other assets (sum of lines 31-34)	694, 093		=	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	32, 788, 248		0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	3, 152, 189		0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 531, 104	1	0	0	38. 00 39. 00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	83, 334	0	0	0	40.00
41. 00	Deferred income	03, 334	0		0	41.00
42. 00	Accel erated payments	0	Ĭ	Ĭ	Ŭ	42. 00
43.00	Due to other funds	-290, 599, 672	0	o	0	43.00
44.00	Other current liabilities	284, 048		o	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	-285, 548, 997	0	0	0	45. 00
47.00	LONG TERM LIABILITIES	Ι ο	Ι	ا		1 47 00
46. 00 47. 00	Mortgage payable	55, 555	0	=	0	46. 00 47. 00
48. 00	Notes payable Unsecured Loans	35, 555	0		0	48.00
49. 00	Other long term liabilities	39, 558, 881	0	=	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39, 614, 436			0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-245, 934, 561	0	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	278, 722, 809				52. 00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	278, 722, 809		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	32, 788, 248	0	0	0	60.00
	47)	I	I	ı l		l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0168

					То	12/31/2018	Date/Time Pre 5/30/2019 3:4	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	F 00	
4.00		1.00	2.00			4. 00	5. 00	4 00
1.00	Fund balances at beginning of period		254, 828, 213			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		23, 894, 596	1		0		2.00
3. 00 4. 00	Additions (credit adjustments) (specify)		278, 722, 809		0	U	0	3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)				0		0	4. 00 5. 00
6. 00					0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0		O	0	O	10. 00
11. 00	Subtotal (line 3 plus line 10)		278, 722, 809			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	270, 722, 007		0	O	0	12. 00
13. 00	beddetrons (debrt day dstillerits) (specify)				0		0	13. 00
14. 00					0		0	14. 00
15. 00					0		0	15. 00
16. 00		o			0		0	16. 00
17. 00		o			0		0	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		278, 722, 809			0		19. 00
	sheet (line 11 minus line 18)							
		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	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8. 00 9. 00			0					8. 00
	Total additions (sum of line 4-9)		Ü		0			9. 00 10. 00
10. 00 11. 00	Subtotal (line 3 plus line 10)				0			10.00
12. 00	Deductions (debit adjustments) (specify)	٩	0		U			12.00
13. 00	beductions (debit adjustments) (specify)		0					13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	0	0		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			O			19. 00
	Ishoot (Tine II minus IIIIe 10)	ı L		I .	1			1

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

				То	12/31/2018	Date/Time Prep 5/30/2019 3:48	
	Cost Center Description		Inpati ent		Outpati ent	Total	J PIII
	oost oonton bescription		1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES		1.00		2.00	0.00	
	General Inpatient Routine Services						
1.00	Hospi tal		10, 725, 06	9		10, 725, 069	1. 00
2.00	SUBPROVI DER - 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)		10, 725, 06	9		10, 725, 069	10.00
	Intensive Care Type Inpatient Hospital Services				'		
11.00	INTENSIVE CARE UNIT			0		0	11. 00
12.00	CORONARY CARE UNIT			0		0	12.00
13.00	BURN INTENSIVE CARE UNIT			0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT			0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes		0		0	16.00
	11-15)						
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		10, 725, 06	9		10, 725, 069	17. 00
18. 00	Ancillary services		227, 648, 73	2	265, 377, 014	493, 025, 746	18. 00
19. 00	Outpati ent servi ces		39, 63	17	1, 120, 634	1, 160, 271	19. 00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21. 00
22. 00	HOME HEALTH AGENCY				0	0	22. 00
23. 00	AMBULANCE SERVICES			0	0	0	23. 00
24. 00	CMHC				0	0	24. 00
24. 10	CORF			0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)			0	0	0	25. 00
26. 00	HOSPI CE			0	0	0	26. 00
27. 00	OTHER (SPECIFY)			0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst.	238, 413, 43	8	266, 497, 648	504, 911, 086	28. 00
	G-3, line 1)						
29. 00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)				80, 320, 738		29. 00
30.00	ADD (SPECIFY)			0	00, 320, 730		30.00
31.00	ADD (SPECIFY)			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)			۰	o		36. 00
37. 00	DEDUCT (SPECIFY)			0	ď		37. 00
38. 00	DEBOOT (OF EOTH)			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)				n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			80, 320, 738		43. 00
	to Wkst. G-3, line 4)				,,		
	·					!	•

Heal th	Financial Systems LUTHERAN MUSCULOSKI	ELETAL CENTER		u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0168	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nanad.
			To 12/31/2018	5/30/2019 3:4	
				37 307 2017 3. 4	O piii
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		504, 911, 086	1. 00
2.00	Less contractual allowances and discounts on patients' accour			400, 845, 844	•
3.00	Net patient revenues (line 1 minus line 2)			104, 065, 242	ı
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		80, 320, 738	4.00
5.00	Net income from service to patients (line 3 minus line 4)	,		23, 744, 504	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
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			150, 098	24. 00

150, 098 23, 894, 602

23, 894, 596 29. 00

25. 00 26. 00

27.00

28.00

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 ROUNDING

Heal th	Financial Systems LUTHERAN MUSC	CULOSKELETAL CENTER	In Lie	u of Form CMS-2	2552-10	
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0168	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre 5/30/2019 3:4		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD			1.00		
	CAPITAL FEDERAL AMOUNT				1	
1.00	Capital DRG other than outlier	739, 131 0	1			
1. 01						
2.00						
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the c	east reporting period (see inst	ructions)	0 14. 86	1	
4.00	Number of interns & residents (see instructions)	ost reporting perrod (see rist	i uctions)	0.00		
5. 00	Indirect medical education percentage (see instructions			0.00		
6.00	Indirect medical education adjustment (multiply line 5		, columns 1 and	0		
	1.01) (see instructions)					
7. 00						
8.00	Percentage of Medicaid patient days to total days (see	instructions)		0.00		
9.00	Sum of lines 7 and 8			0. 00 0. 00		
10.00						
11.00	.00 Disproportionate share adjustment (see instructions) 2.00 Total prospective capital payments (see instructions)				11. 00 12. 00	
12.00	Total prospective capital payments (see mistructions)			739, 131	12.00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instruction			0		
2. 00 3. 00	Program inpatient ancillary capital cost (see instructi			0		
4. 00	Total inpatient program capital cost (line 1 plus line Capital cost payment factor (see instructions)	2)		0		
5.00	Total inpatient program capital cost (line 3 x line 4)			0		
3.00	Trotal Tripati ent program capital cost (Tric 3 X Tric 4)			0	3.00	
				1. 00		
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00	
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circu	metancos (soo instructions)		0		
3.00	Net program inpatient capital costs for extraordinary circumstance of the program inpatient capital costs (line 1 minus line			0		
4. 00	Applicable exception percentage (see instructions)	2)		0.00		
5. 00	Capital cost for comparison to payments (line 3 x line	4)		0		
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00	
7.00	Adjustment to capital minimum payment level for extraor	dinary circumstances (line 2 x	(line 6)	0	7. 00	
8.00	Capital minimum payment level (line 5 plus line 7)			0		
9.00	Current year capital payments (from Part I, line 12, as			0		
10. 00 11. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level			0		
11.00	Worksheet L, Part III, Line 14)	over capital payment (110m pil	oi yeai	U	11.00	
12. 00	Net comparison of capital minimum payment level to capi	tal payments (line 10 plus lin	ne 11)	0	12. 00	
13. 00	Current year exception payment (if line 12 is positive,			0		
14.00	Carryover of accumulated capital minimum payment level		following period	0	14. 00	
	(if line 12 is negative, enter the amount on this line)					
4= 0-					15.00	
15.00				0		
16.00	Current year allowable operating and capital payment (s Current year operating and capital costs (see instructi Current year exception offset amount (see instructions)	ons)		0	16. 00	