This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0168 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 Ti me: 1:38 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened(5) Amended

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 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 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX		
	1	2	SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

·		Title	XVIII			
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
HOSPI TAL	0	314	17, 356	0	0	1.00
SUBPROVIDER - IPF	0	0	0		0	2.00
SUBPROVIDER - IRF	0	0	0		0	3.00
SWING BED - SNF	0	0	0		0	5.00
SWING BED - NF	0				0	6.00
SKILLED NURSING FACILITY	0	0	0		0	7.00
NURSING FACILITY	0				0	8.00
HOME HEALTH AGENCY I	0	0	0		0	9.00
RURAL HEALTH CLINIC I	0		0		0	10.00
FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
CMHC I	0		0		0	12.00
TOTAL	0	314	17, 356	0	0	200.00
	HOSPITAL SUBPROVIDER - IPF SUBPROVIDER - IRF SWING BED - SNF SWING BED - NF SKILLED NURSING FACILITY NURSING FACILITY HOME HEALTH AGENCY I RURAL HEALTH CLINIC I FEDERALLY QUALIFIED HEALTH CENTER I CMHC I TOTAL	1.00	Title V	1.00 2.00 3.00	Title V	Title V

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

is this the first cost reporting period during which residents in approved GME programs trained

during in this cost reporting period of HRSA THC program. (see instructions)

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

Teaching Hospitals that Claim Residents in Nonprovider Settings

Health Financial Systems	LUTHERAN M	IUSCULOSKELETAL CENTER	2	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			CN: 15-0168 Pe	eriod: com 01/01/2023	Worksheet S-2 Part I Date/Time Pre 5/30/2024 1:3	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Ye period that begins on or after			·lhis base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the nuresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column 2 divided by (column 1	s yes, or your facili mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64.00
or (cordinir r drvi ded by (cordinir	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective f	or cost report	ing periods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of		ry care resident	0.00	0. 00	0. 000000	66 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi	occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of				
(column 1 divided by (column 1	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col.	
	Ü	, and the second	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.00000	67.00

OSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCI	l: 15-0168	Period: From 01/01/20	023 P	orkshee art I		
				To 12/31/20)23 D 5	ate/Tim /30/202	e Pre 4 1:3	pared 8 pm
						1. 00)	
	<u>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87</u> For a cost reporting period beginning prior to October 1, 2022 MAC to apply the new DGME formula in accordance with the FY 20 (August 10, 2022)?	2, did you ob	tain permis	sion from your				68. 0
				1	1.00	2. 00	3. 00	
0. 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or o	does it conta	in an IPF s	ubprovi der?	N	T		70. C
1. 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility trai	er "Y" for ye	s or "N" fo	no. (see			0	71. 0
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Ente Column 3: If column 2 is Y, indicate which program year began (see instructions)	er "Y" for ye	s or "N" fo	no.				
5. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), o	or does it co	ntain an IR	=	N			75. C
6. 00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved						0	76.0
	recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting p	ning program Column 3: If	in accordan column 2 is	ce with 42 Y,				
						1. 00)	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes a Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? En	ter	N N		80. (81. (
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 7 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				no.	N		85. 86.
7. 00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	nder sectio	٦		N		87.
				Approved f Permanent Adjustmen (Y/N) 1.00	t t	Number Approv Permand Adjustme 2.00	ed ent ents	
3. 00	Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N	T	2.00		88.
			Wkst. A Lin No.	Date		Approv Permane Adjustm Amount Dischar	ent Jent Per rge	
P. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A lir on which the per discharge permanent adjustment approval was becolumn 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA targer discharge.	pased. period get amount	1.00	2.00		3.00		89.
	Column 3: Enter the amount of the approved permanent adjustmer TEFRA target amount per discharge.	ii io the				VIV		
	Title V and VIV Coming			1. 00		XI X 2. 00		
. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital	servi ces? En	ter "Y" for	N		Υ		90.
. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the		either in	N		Υ		91.
00	full or in part? Enter "Y" for yes or "N" for no in the applic Are title XIX NF patients occupying title XVIII SNF beds (dual	certi fi cati	on)? (see			N		92.
00	instructions) Enter "Y" for yes or "N" for no in the applicable Does this facility operate an ICF/IID facility for purposes of		XIX? Enter	N		N		93.
00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.	nd "N" for no	in the	N		N		94.
	applicable column. If line 94 is "Y", enter the reduction percentage in the appli Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.			0. 00 N		0. 00 N		95. 96.
. OO	If line 96 is "Y", enter the reduction percentage in the appli	cable column		0.00		0. 00	,	97.

alth Financial Systems LUTHERAN MUSCUL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	OSKELETAL CENTER Provider C	CN: 15-0168	Peri od:	u of Form CN Worksheet S	
			From 01/01/2023 To 12/31/2023	Part I Date/Time I	Prepare
			V	5/30/2024 XI X	1:38 pm
			1. 00	2.00	
B.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y' column 1 for title V, and in column 2 for title XIX.			N	Y	98.
3.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98.
3.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98.
3.03 Does title V or XIX follow Medicare (title XVIII) for a confirmed reimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.	yes or "N" for	no in column	1	N	98.
B. O4 Does title V or XIX follow Medicare (title XVIII) for a Conformation of the c			N	N	98.
B. 05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98.
3.06 Does title V or XIX follow Medicare (title XVIII) when compts. I through IV? Enter "Y" for yes or "N" for no in column 2 for title XIX.	N	Y	98.		
Rural Providers 05.00 Does this hospital qualify as a CAH?			N	Τ	105.
16.00 f this facility qualifies as a CAH, has it elected the al	I-inclusive met	thod of paymer			106.
for outpatient services? (see instructions)		. 3			
17.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in column 2: If column 1 is Y and line 70 or line 75 is Y, approved medical education program in the CAH's excluded	umn 1. (see ins do you train I&F IPF and/or IRF	structions) Rs in an			107.
Enter "Y" for yes or "N" for no in column 2. (see instruction of this facility is a REH (line 3, column 4, is "12"), is reimbursement for L&R training programs? Enter "Y" for yes	it eligible for				107
instructions) 8.00 s this a rural hospital qualifying for an exception to tl CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ne CRNA fee sche	edul e? See 42	. N		108
	Physi cal	Occupati onal		Respirator	ТУ
9.00 f this hospital qualifies as a CAH or a cost provider, and therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	Occupati onal 2.00	Speech 3.00	Respirator 4.00	109
therapy services provided by outside supplier? Enter "Y"	1.00				
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 re N	2.00	3.00	1.00	109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 Te N tal Demonstrati	2.00 on project (§ r "N" for no.	3.00 410A If yes,	4.00	109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and N	1.00 Te N tal Demonstrati	2.00 on project (§ r "N" for no.	3.00 410A If yes, ugh 215, as	1. 00 N	109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Napplicable.	tal Demonstrati "Y" for yes or Worksheet E-2, I	2.00 on project (§ r "N" for no. lines 200 thro community period? Enter enter the n column 2.	3.00 410A If yes, ugh 215, as	1.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D. 00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and vapplicable. 1. 00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for	tal Demonstrati "Y" for yes or Worksheet E-2, I	2.00 I on project (§ r "N" for no. lines 200 thro Community period? Enter enter the n column 2. s; and/or "C"	3.00 410A If yes, ugh 215, as 1.00 N	1. 00 N	1109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and wapplicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.	tal Demonstrati "Y" for yes or Worksheet E-2, I the Frontier (cost reporting column 1 is Y, participating in additional beds	2.00 con project (§ "N" for no. lines 200 through the period? Enter enter the n column 2. s; and/or "C"	3.00 410A If yes, ugh 215, as	1. 00 N	1109
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. D.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and wapplicable. D.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.	tal Demonstrati "Y" for yes or Worksheet E-2, I the Frontier (cost reporting column 1 is Y, participating in additional beds ealth Model reporting column 1 is cipating in the	2.00 on project (§ r "N" for no. lines 200 thro community period? Enter enter the n column 2. s; and/or "C"	3.00 410A If yes, ugh 215, as 1.00 N	1. 00 N	1109
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therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Napplicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "N" for no.	tal Demonstratic "Y" for yes or Worksheet E-2, I to the Frontier (cost reporting column 1 is y, participating in additional beds and the cost or "N" for no B, or E only) "93" percent e (includes ders) based on (" for yes or	2.00 I on project (§ "N" for no. lines 200 through the period? Enter enter the n column 2. s; and/or "C" 1.00 N	3.00 410A If yes, ugh 215, as 1.00 N	1. 00 N	109 110 1110 1111 1112
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and vapplicable. 1.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Mi scellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provid the definition in CMS Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y"	tal Demonstratic "Y" for yes or Worksheet E-2, I to the Frontier (cost reporting column 1 is y, participating in additional beds and the cost or "N" for no B, or E only) "93" percent e (includes ders) based on (" for yes or	2.00 on project (§ r "N" for no. lines 200 thro community period? Enter enter the n column 2. s; and/or "C" 1.00 N	3.00 410A If yes, ugh 215, as 1.00 N	1. 00 N	1109

PO Box:					142.00
C+-+-					1142.00
State:	TN	Zi p Code:	3706	7	143.00
				1. 00	
ncluded in Wo	rksheet A?			Υ	144.00
			1. 00	2. 00	
yes or "N" f Medicare uti no in column anged from th umn 1. (See C	for no in column 1 lization for this 2. ne previously file CMS Pub. 15-2, cha	I. If column 1 is scost reporting ed cost report?	N		145. 00
	d on Wkst. A, yes or "N" f Medicare uti no in column anged from th umn 1. (See C	yes or "N" for no in column 1 Medicare utilization for this no in column 2. anged from the previously file	d on Wkst. A, line 74, are the costs for yes or "N" for no in column 1. If column 1 is Medicare utilization for this cost reporting no in column 2. anged from the previously filed cost report? umn 1. (See CMS Pub. 15-2, chapter 40, §4020) If	d on Wkst. A, line 74, are the costs for yes or "N" for no in column 1. If column 1 is Medicare utilization for this cost reporting no in column 2. anged from the previously filed cost report? Numn 1. (See CMS Pub. 15-2, chapter 40, §4020) If	ncluded in Worksheet A? 1.00 2.00 d on Wkst. A, line 74, are the costs for yes or "N" for no in column 1. If column 1 is Medicare utilization for this cost reporting no in column 2. anged from the previously filed cost report? umn 1. (See CMS Pub. 15-2, chapter 40, §4020) If

Health Financial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	!	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	Provi der CCN: 15-0168 Peri Froi To		Worksheet S- Part I Date/Time Pr 5/30/2024 1:	epared:
					1. 00	\perp
147.00 Was there a change in the statist 148.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" f	or no.		N N	147. 00 148. 00
149.00 Was there a change to the simplif	ed cost finding method? E				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or		ent for Part A	and Part B	. (See 42 CFR §41	3. 13)	
155. 00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N N	N	N	156.00
157.00 Subprovi der - I RF 158.00 SUBPROVI DER		N	N 	N	N	157. 00 158. 00
159. 00 SNF		N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N	N	N	160.00
161. 00 CMHC			N N	N	N	161.00
161. 10 CORF			N N	N	N	161. 10
					1. 00	
Mul ti campus						
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has on	e or more camp	uses in diff	ferent CBSAs?	N	165. 00
	Name	County	State Z	ip Code CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00 4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	00 166. 00
					1. 00	
Health Information Technology (HI	T) incentive in the Americ	ran Recovery ar	nd Reinvestm	ent Act	1.00	
167.00 s this provider a meaningful use				one not	Υ	167. 00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and ís a meanin	ıgful user (lin		'), enter the		168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user, doe	s this provide				168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 iš "Y") and				9. 9	99169.00
transition ractor. (see mistracti	5113)			Begi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR	peginning date and ending	date for the r	eporti ng	1. 00	2. 00	170. 00
period respectively (mm/dd/yyyy)						
				1.00	2. 00	
171.00 ffline 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, co	I. 6? Enter	on N		0 171.00

Heal th	Financial Systems LUTHERAN MUSCULOS	SKELETAL CENTE	R	In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II	2
					5/30/2024 1:3	
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI	EMENT OUESTLON	NAI DE	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Imm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			ter all dates in	the	
	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		instructions			1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Drogram2 If	1.00 N	2. 00	3. 00	2.00
3. 00	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providericers, medical staff, management personnel, or members of directors through ownership, control, or family and oth	mn 3, "V" for ng management offices, drug der or its of the board	N			3.00
	relationships? (see instructions)			_	_	
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffi	for Compiled, ailable in	N N			4.00
0.00	those on the filed financial statements? If yes, submit re					0.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, i	s the provide	er N		6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv- cost reporting period? If yes, see instructions.		wed during th	ne N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	n N		9. 00
10.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & Rin an Ap	proved 	N	Y/N	11.00
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			cost reporting	N N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsur- instructions.	ance amounts w	aived? If yes	s, see	N	14. 00
15 00	Bed Complement Did total beds available change from the prior cost report	ing periode if	V06 500 1-	structions	Y	15 00
13.00	Total beus avairable change from the prior cost report		<u>yes, see ins</u> t A		rt B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	04/10/2024	Y	04/10/2024	16.00
17. 00	date of the PS&R Report used in columns 2 and 4 (see 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

Heal th	Financial Systems LUTHERAN MUSCULO	SKELETAL CENTER		In Lie	u of Form CMS-	2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-0168	Peri od: From 01/01/2023 To 12/31/2023		epared:			
		Descri	ption	Y/N	Y/N	JO PIII			
		0		1. 00	3.00				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00			
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00				
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00			
21.00	records? If yes, see instructions.					21.00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	CEPT CHILDRENS H	OSPI TALS)						
22. 00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions				22.00			
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made du	ring the cost		23. 00			
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost r	eporting period?		24.00			
25. 00	Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period	? If yes, see		25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost reporti	ng period?	If yes, see		26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	f yes, submit		27. 00					
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credite	t reporting		28. 00					
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	. 0		29. 00					
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	•		30.00					
31. 00	instructions. Has debt been recalled before scheduled maturity without i		31.00						
	i nstructi ons. Purchased Servi ces								
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through c	ontractual		32.00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	oplied pertainin	g to compet	itive bidding? If	}	33.00			
	Provi der-Based Physi ci ans								
34. 00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wit	h provider-	based physicians?	•	34.00			
35. 00		kisting agreemen nstructions.	ts with the	provi der-based		35. 00			
	,, , , , , , , , , , , , , , , , , , ,			Y/N	Date				
				1.00	2. 00				
0/ 00	Home Office Costs					1 0, 05			
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	orepared by the	home office	? Y		36. 00 37. 00			
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			f Y	12/31/2022	38.00			
39. 00	, · · · · · · · · · · · · · · · · · · ·			s, N		39.00			
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	If yes, see	N		40.00			
	i nstructi ons.								
	Cost Depart Dranger Contact Information	1. (00	2.	00				
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KRI SSY		SCRUGGS		41.00			
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEALT	TH SYSTEMS			42.00			
43. 00	preparer. Enter the telephone number and email address of the cost	423-802-7341		KRI SSY_SCRUGGS	@CHS. NET	43.00			
	report preparer in columns 1 and 2, respectively.								

Heal th	Financial Systems	LUTHERAN MUSCULOS	LOSKELETAL CENTER				In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Prov	ider CCN:	15-0168	Peri		Worksheet S-2)	
						From To	12/31/2023		nared.	
							127 0 17 2020	5/30/2024 1:3		
				3. 00						
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the ti	tle/position	MANAGER,	REVENUE	MANAGEMEN [*]	Γ			41.00	
	held by the cost report preparer in column	ns 1, 2, and 3,								
	respecti vel y.									
42.00	Enter the employer/company name of the cos	st report							42.00	
	preparer.									
43.00	Enter the telephone number and email addre								43.00	
	report preparer in columns 1 and 2, respec	cti vel y.								

Heal th Financial Systems LUTHERAN MUSCULOSKELETAL CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN | In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0168

Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Tirl post O/P Visits / Trips						-	Γο 12/31/2023		
Component Worksheet A No. of Beds Bed Days Available CAH/REH Hours Title V									o pili
Component Worksheet A Line No. No. of Beds Bed Days Available CAH/REH Hours Title V Line No. 1.00 2.00 3.00 4.00 5.00									
Component Worksheet A No. of Beds Bed Days Available A									
Line No. Available		Component	Workshoot A	No	of Pode	Pod Dave	CAH /DEH House		
PART I - STATISTICAL DATA		Component		INO.	or beus		CAN/ KEN HOULS	litte v	
PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 1.00					2 00		4 00	5 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 SURGICAL INTENSIVE CARE (SPECIFY) 11.00 Total (see instructions) 13.00 Total (see instructions) 14.00 Total (see instructions) 15.00 CAH visits		PART I - STATISTICAI DATA	1.00	· · · · ·	2.00	3.00	4.00	3.00	
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 15.00 CAH visits	1 00		30.00	l l	38	13 74	5 0.00	0	1 00
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1.00		00.00		00	10, 710	0.00	Ĭ	1.00
For the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURRI INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 Total (see instructions) 9.00 CORONARY CARE UNIT 9.0									
3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 3.00 4.00 5.00 5.00 6.00 7.00 8.10 9.00	2 00								2 00
4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.01 NEONATAL INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 11.00 Total (see instructions) 4.00 4.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 6									
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 13,745 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 10.00 11.00 12.00 14.00 15.00 CAH visits									
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.01 NEONATAL INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 143.00 15.00 CAH visits								0	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.01 NEONATAL INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 9.00 SURGICAL INTENSIVE CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 13.745 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
Beds (see instructions)					38	13 74	0.00		1
8.00 INTENSIVE CARE UNIT 31.00 0 0 0.00 0 8.00 8.01 NEONATAL INTENSIVE CARE UNIT 31.01 0 0 0 0.00 0 8.01 9.00 CORONARY CARE UNIT 32.00 0 0 0 0.00 0 9.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 11.	7.00	`			00	10, 710	0.00	Ĭ	7.00
8.01 NEONATAL INTENSIVE CARE UNIT 31.01 0 0 0.00 0 8.01 9.00 CORONARY CARE UNIT 32.00 0 0 0 0.00 0 9.00 10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0.00 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 11.00 11.00 11.00 NURSERY 43.00 0 0 13.00 14.00 15.00 CAH visits 38 13,745 0.00 0 15.00	8 00		31 00		0	,	0.00	0	8 00
9.00 CORONARY CARE UNIT 32.00 0 0.00 0 9.00 10.0		I I				1		l .	1
10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00 11.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0.00 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 38 13,745 0.00 0 15.00						1			
11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0.00 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 43.00 0 13.00 14.00 Total (see instructions) 38 13,745 0.00 0 14.00 15.00 CAH visits 0 15.00		· ·				l .			1
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 43.00 14.00 Total (see instructions) 15.00 CAH visits 12.00 0 13.00 0 14.00 0 15.00		· ·			-	1			
13.00 NURSERY 43.00 0 13.00 14.00 Total (see instructions) 38 13,745 0.00 0 14.00 15.00 CAH visits 0 15.00		· ·	01.00	1	Ü	`	0.00	Ĭ	
14.00 Total (see instructions) 15.00 CAH visits 38 13,745 0.00 0 14.00 0 15.00		1	43 00	J				0	
15. 00 CAH vi si ts 0 15. 00			10.00		38	13 74	0.00		
		, ,			00	10, 710	0.00		
101 10 1121 11041 0 4114 1101 10		I I					0.00		
16.00 SUBPROVIDER - I PF 40.00 0 0 16.00		l e	40.00		0	,			
17. 00 SUBPROVI DER - RF 41. 00 0 0 17. 00		l e				1			
18.00 SUBPROVI DER 18.00			111.00		ŭ				
19.00 SKILLED NURSING FACILITY 44.00 0 0 19.00		l e	44 00		0	,)	0	
20. 00 NURSING FACILITY 45. 00 0 0 0 20. 00				1	_				
21.00 OTHER LONG TERM CARE 46.00 0 0 21.00				1	0		-		
22. 00 HOME HEALTH AGENCY 101. 00 0 22. 00					Ü	`		0	
23.00 AMBULATORY SURGI CAL CENTER (D. P.) 115.00 23.00									1
24.00 HOSPICE 116.00 0 0 24.00					0	,)		
24. 10 HOSPICE (non-distinct part) 30.00 24.10					ŭ				
25. 00 CMHC - CMHC 99. 00 0 25. 00								0	
25. 10 CMHC - CORF 99. 10		· ·							
26.00 RURAL HEALTH CLINIC 88.00 0 26.00				1					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25		· ·		1				-	
27.00 Total (sum of lines 14-26) 38 27.00		1	07.00		38				
28.00 Observation Bed Days					00			0	
29.00 Ambul ance Trips 29.00								_	
30.00 Employee discount days (see instruction) 30.00									
31.00 Employee discount days - IRF									
32.00 Labor & deli very days (see instructions) 0 0 32.00		. 3			0				
32.01 Total ancillary labor & delivery room 32.01		, , , , , , , , , , , , , , , , , , ,			· ·]			
outpatient days (see instructions)									
33.00 LTCH non-covered days 33.00	33. 00								33.00
33.01 LTCH site neutral days and discharges 33.01									
34.00 Temporary Expansi on COVI D-19 PHE Acute Care 30.00 0 0 34.00	34.00		30. 00		0	(o	0	34.00

Provider CCN: 15-0168

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 1: 38 pm

		I/P Davs	/ O/P Visits	/ Trips	Full Time I	<u> 5/30/2024 1: 3</u> Equi val ents	l pili
				po			
	0	T' 11 . \0.0011	T. 11 . VIV. I	T. I. I. A. I.	T. L. L. L.		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8.00	& Residents 9.00	Payrol I 10.00	
	PART I - STATISTICAL DATA	0.00	7.00	6.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	943	323	3, 734			1.00
1.00	8 exclude Swing Bed, Observation Bed and	710	323	0, 701			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 127	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	943	323	3, 734			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
8. 01 9. 00	NEONATAL INTENSIVE CARE UNIT	0	O O	0			8. 01
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0			9. 00 10. 00
11. 00	I .		0	0			11.00
12. 00			U	Ü			12.00
13. 00	` ′		0	0			13.00
14. 00	l .	943	323	3, 734	0.00	334. 27	
15. 00	, ,	0	0	0,701	0.00	001127	15.00
15. 10	l .	o	0	0			15. 10
16.00	SUBPROVI DER - I PF	o	0	0	0.00	0.00	16.00
17. 00		O	0	0	0.00	0.00	17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0. 00	0.00	19.00
20.00	NURSING FACILITY		0	0	0. 00	0.00	20.00
21. 00				0	0. 00		
22. 00		0	0	0	0.00		
23. 00	` ,				0. 00		
24. 00		0	0	0	0. 00	0. 00	
24. 10				0			24. 10
25. 00		0	0	0	0.00		
25. 10		0	0	0	0.00		
26. 00 26. 25	I .	0	0	0	0. 00 0. 00		
26. 25	I .	١	U	Ü	0.00		
28. 00			o	1, 929		334.27	28.00
29. 00	1	0		1, 727			29.00
30.00				0			30.00
31. 00	1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0			31.00
32. 00		o	o	0			32.00
32. 01	7]	0			32. 01
	outpatient days (see instructions)						
33. 00		0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Heal th Financial Systems LUTHERAN MUSCULOSKELETAL CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCM Provider CCN: 15-0168

				To	12/31/2023	Date/Time Pre 5/30/2024 1:3	pared:
		Full Time		Di sch	arges	37 307 2024 1.3	o piii
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART I - STATISTICAL DATA		0	2/2	10/	1 457	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		U	363	126	1, 457	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			403	ol		2.00
3.00	HMO IPF Subprovider				o		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						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 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	363	126	1, 457	14.00
15.00	CAH visits					,	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF	0. 00	0	0	o	0	16.00
17.00	SUBPROVI DER - I RF	0.00	0	0	0	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	
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0. 00 0. 00					22. 00 23. 00
24.00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					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 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)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)						33.00
33. 00	LTCH non-covered days LTCH site neutral days and discharges			0			33.00
	Temporary Expansion COVID-19 PHE Acute Care						34.00
54.00	Transporting Expansion Covid 17 The Acute Care	1		1	ı		1 54.00

Heal th Financial Systems

HOSPITAL WAGE INDEX INFORMATION

West. A Line Number

West. A Line Number

Wighter Reported

Number

		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	5/30/2024 1:3 Average Hourly Wage (col. 4 ÷ col. 5)	o piii
		1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	27, 316, 795	0	27, 316, 795	695, 278. 00	39. 29	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	0. 00 0. 00	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7.00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0.00	7.01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9.00	SNF	44.00	2 102 205	0	0	0.00	0.00	
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		3, 103, 395	0	3, 103, 395	106, 056. 00	29. 26	10.00
11. 00	Contract Labor: Direct Patient		2, 122, 330	0	2, 122, 330	26, 318. 00	80. 64	11.00
12. 00	Care Contract labor: Top level management and other management and administrative		0	0	0	0. 00	0. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		13, 895	0	13, 895	78. 00	178. 14	13.00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14.00
14. 01	wage-related costs Home office salaries		4, 389, 843	0	4, 389, 843	125, 841. 00	34. 88	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0. 00 0. 00	
13.00	- Administrative		0			0.00	0.00	13.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16.00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 01
	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0. 00	0.00	16. 02
	Wage-related costs (core) (see		6, 520, 041	0	6, 520, 041			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19.00	Excluded areas		1, 093, 550	0	1, 093, 550			19.00
20. 00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0	0			20.00
22. 00	B Physician Part A -		0	0	0			22.00
22. 01	Administrative Physician Part A - Teaching		0	_				22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		1, 072, 930	0	1, 072, 930			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0168 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 1:38 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col. 2 ± col. Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 56, 434 56, 434 1, 282. 00 44. 02 26.00 27.00 Administrative & General 5.00 5, 962, 996 -262, 410 5, 700, 586 139, 824. 00 40.77 27.00 28.00 0.00 0.00 28.00 Administrative & General under O contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 103, 555 0 103, 555 2,870.00 36. 08 30.00 Laundry & Linen Service 8.00 0.00 31.00 31.00 0 0.00 0 32.00 32.00 Housekeepi ng 9.00 1.083 Ω 1,083 36.00 30.08 33.00 Housekeeping under contract 670, 238 670, 238 25, 950. 00 25.83 33.00 (see instructions) 50. 33 34.00 Dietary 10.00 151 0 151 3.00 34.00 Dietary under contract (see 35.00 88, 153 C 88, 153 3, 643. 00 24. 20 35.00 instructions) 36.00 Cafeteri a 11.00 0 0 0.00 0.00 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 0 Nursing Administration 441, 217 12, 105. 00 58. 13 38.00 38.00 13.00 262, 410 703, 627 39.00 Central Services and Supply 14.00 580, 851 C 580, 851 24, 131. 00 24.07 39.00 280, 883 280, 883 6, 684. 00 40.00 Pharmacy 15.00 0 42.02 40.00 Medical Records & Medical Records Library 41.00 16.00 55, 423 0 55, 423 2, 145. 00 25. 84 41.00

328, 394

0

328, 394

6, 765. 00

0.00

48. 54 42. 00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0168	Peri od: Worksheet S-3

						rom 01/01/2023 o 12/31/2023		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		28, 075, 186	0	28, 075, 186	724, 871. 00	38. 73	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 103, 395	0	3, 103, 395	106, 056. 00	29. 26	2.00
	instructions)							
3.00	Subtotal salaries (line 1		24, 971, 791	0	24, 971, 791	618, 815. 00	40. 35	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 526, 068	0	6, 526, 068	152, 237. 00	42. 87	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 592, 971	0	7, 592, 971	0.00	30. 41	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		39, 090, 830	0	39, 090, 830	771, 052. 00	50. 70	6.00
7.00	Total overhead cost (see		8, 569, 378	0	8, 569, 378	225, 438. 00	38. 01	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	Peri od: From 01/01/2023	Worksheet S-3
			Date/Time Prepared

	To 12/31/2023	B Date/Time Pre 5/30/2024 1:3	
		Amount	•
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	552, 393	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)	4, 991, 767	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	8, 744	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	18, 608	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	6, 485	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		131, 453	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
		1, 507, 416	
18. 00	Medicare Taxes - Employers Portion Only	352, 541	
19. 00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	44, 185	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	e 0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23.00
24. 00		7, 613, 592	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0168	Period: Worksheet S-3

		o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
	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	2, 122, 330	7, 613, 592	1.00
2.00	Hospi tal	2, 122, 330	7, 613, 592	2.00
3. 00	SUBPROVIDER - IPF	0	0	3.00
4. 00	SUBPROVI DER - I RF	0	0	4.00
5. 00	Subprovi der - (0ther)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8. 00	SKILLED NURSING FACILITY	0	0	8.00
9. 00	NURSING FACILITY	0	0	9.00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	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 I	0	0	17.00
18. 00	Other	0	0	18.00

Health Financial Systems		IUSCULOSKELETAL CENTER	?	In Lie	u of Form CMS-2	
HOSPITAL UNCOMPENSATED AND IND	IGENT CARE DATA	Provi der C	CN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023		epared:
					1. 00	
PART I - HOSPITAL AND HO						4
	ent Care Cost-to-Charge Ratio)			0.000100	4
1.00 Cost to charge ratio (se					0. 088139	1.00
Medicaid (see instruction					0 (01 0(0	4
2.00 Net revenue from Medicai					8, 631, 262	
	supplemental payments from Me			0	N 	3.00
	ine 2 include all DSH and/or			ai d?	N	4.00
	nter DSH and/or supplemental	payments from Medica	a		0	
6.00 Medicaid charges 7.00 Medicaid cost (line 1 ti	mag ling ()				72, 942, 129 6, 429, 046	
,	•	d program (see instri	ictions)		0, 429, 046	1
	<u>revenue and costs for Medicai</u> Ince Program (CHIP) (see inst					0.00
9.00 Net revenue from stand-a		ructions for each fit	16)		0	9.00
10.00 Stand-alone CHIP charges					0	1
11. 00 Stand-al one CHIP cost (I					0	
12.00 Difference between net in		alone CHIP (see instri	ictions)		l ől	1
	vernment indigent care progra)		12.00
	or local indigent care progra				0	13.00
	vered under state or local in				l ol	
10)		3 1 3	•			
15.00 State or local indigent	care program cost (line 1 ti	mes line 14)			0	15.00
	revenue and costs for state of				0	16. 00
	otal unreimbursed cost for Me	edicaid, CHIP and sta	te/local indi	gent care progra	ms (see	
instructions for each li						4
	ns, or endowment income restr				0	1
	opriations or transfers for s				0	
	for Medicaid , CHIP and stat	te and local indigent	care program	s (sum of lines	0	19.00
8, 12 and 16)			Uni nsured	Lacusod	Total (col. 1	
			patients	Insured patients	+ col . 2)	
			1.00	2.00	3.00	
Uncompensated care cost	(see instructions for each I	ine)	1.00	2.00	3.00	
	d uninsured discounts (see in		8, 822, 65	9, 231	8, 831, 890	20.00
	ed for charity care and unins	,	777, 62	•		
instructions)		(,	., ==.		
	patients for amounts previous	sly written off as		0 0	0	22.00
charity care		•				
23.00 Cost of charity care (se	ee instructions)		777, 62	9, 231	786, 851	23.00
25: 00 003t 01 Chairty Care (30						
23.00 0031 01 Chart ty care (3						
24.00 Does the amount on line	,				1. 00 N	24.00

imposed on patients covered by Medicaid or other indigent care program?

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.00 Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

27.01 Medicare allowable bad debts (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0 25.00

26.00

27.00

27.01

28.00

29.00

30.00

1, 523, 526

1, 495, 650

18, 119

27, 876

141, 582

928, 433

928, 433 31.00

25.00

stay limit

26.00 Bad debt amount (see instructions)

PART II - HOSPITAL DATA Date/Time Preparal Date/ Imme Preparal Date/Time Preparal Date		Financial Systems LUTHERAN MUSCULOSK				u of Form CMS-2		
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) 0.088139 Medicaid (see instructions for each line) 0.088139 Medicaid (see instructions or life line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	CN: 15-0168		Date/Time Pre	pared:	
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions) 0.088139 Medicaid (see instructions for each line) 0.088139 Medicaid (see instructions or life line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 Medicaid charges 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139 0.088139						1.00		
Uncompensated and Indigent Care Cost-to-Charge Ratio 0.008139		DART II - HOSDITAI DATA				1.00		
Cost to charge ratio (see instructions) Medicaid (see instructions for each line)							1	
Medicald (see Instructions for each line) Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? If line 4 is no, then enter BSH and/or supplemental payments from Medicaid? If line 4 is no, then enter BSH and/or supplemental payments from Medicaid? If line 4 is no, then enter BSH and/or supplemental payments from Medicaid? If line 4 is no, then enter line 6 or line 1 in the 1 in	. 00					0. 088139	1.0	
Did you receive DSH or supplemental payments from Medicaid?								
If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	. 00	Net revenue from Medicaid					2.0	
If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	. 00	Did you receive DSH or supplemental payments from Medicaid?					3.0	
If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	. 00	If line 3 is yes, does line 2 include all DSH and/or suppler	mental payment	ts from Medic	cai d?		4.0	
Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions) Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-alone CHIP cost (line 1 times line 10) Stand-alone CHIP cost (line 1 times line 10) 1 times tate or local government indigent care program (see instructions for each line) 1 times tate or local indigent care program (Not included on lines 2, 5 or 9) 1 times for patients covered under state or local indigent care program (Not included in lines 6 or 10) 1 times line 10) 1 times line 10) 1 times line 10 1 times line 10) 1 times line 10	. 00						5.00	
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Stand-alone CHIP charges 1 1 2 2 2 2 2 2 2 2			s for each lir	ne)			1	
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instructions for each line) 7.00 Private grants, donations, or endowment income restricted to funding charity care 8.00 Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients patients + col. 2) 1.00 2.00 3.00 Uncompensated care cost (see instructions for each line) Cost of patients approved for charity care and uninsured discounts (see 777, 620 9, 231 786, 851 2 instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Results of the patients of the						ms (see	10.0	
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Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines Uninsured patients patients patients + col. 2)	7. 00		o fundi na char	ritv care			17. C	
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Description		8, 12 and 16)						
Uncompensated care cost (see instructions for each line) Output (See instructions) Output (See instr						,		
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charity care (see instructions) 777,620 9,231 786,851 2	2 00		ton off as				22.0	
8.00 Cost of charity care (see instructions) 777,620 9,231 786,851 2	2.00		ren on as		0	ا	22.0	
1.00	3 00	3		777 6	20 0 221	786 851	23 0	
	5.00	oost or original by our of (300 mistractions)		777,0	20, 7, 231	700, 001	23.0	
						1, 00		
, of poor the amount on time 20 cor. 2, therage charges for patrell days bevold a reliation stay fill to the two	4. 00	Does the amount on line 20 col. 2. include charges for patie	ent days bevor	nd a Length o	of stay limit	N	24.0	

imposed on patients covered by Medicaid or other indigent care program?

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.00 Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

27.01 Medicare allowable bad debts (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0 25.00

26.00

27.00

27.01

28. 00 29. 00

30.00

1, 523, 526

1, 495, 650

18, 119

27, 876

141, 582

928, 433

928, 433 31.00

25.00

stay limit

26.00 Bad debt amount (see instructions)

	Financial Systems LU SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	THERAN MUSCULOSE OF EXPENSES	Provider C		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
KLULAS	STITCATION AND ADJUSTMENTS OF TRIAL BALANCE C	JI EXPENSES	Flovidei C	F	rom 01/01/2023		
				1	o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Recl assi fi ed	,
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		770 50/	770 50/	2 21/ 000	2 007 407	1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP		779, 506 6, 778, 129	1			
3.00	00300 OTHER CAP REL COSTS		0, 770, 127	0, 7,0, 12,		0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	56, 434	192, 163			6, 359, 687	4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	5, 962, 996 103, 555	58, 934, 302 1, 912, 763			55, 096, 623 3, 068, 567	
8. 00	00800 LAUNDRY & LINEN SERVICE	103, 555	276, 206			276, 206	1
9. 00	00900 HOUSEKEEPI NG	1, 083	617, 039	618, 122	-5, 773	612, 349	
10.00	01000 DI ETARY	151	175, 202	1		175, 353	
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0 441, 217	60, 644	0 501, 861	_	0 764, 127	
14. 00	01400 CENTRAL SERVICES & SUPPLY	580, 851	2, 041, 752	1			
15. 00	01500 PHARMACY	280, 883	1, 039, 491			320, 217	
16. 00 17. 00	O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE	55, 423 328, 394	821, 836 23, 928	1		869, 464 352, 322	
18. 00	01850 OTHER GENERAL SERVICES	328, 374	23, 920	332, 322	0	332, 322	1
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 1 & R SERVICES-SALARY & FRINGES APPRV 02200 1 & R SERVICES-OTHER PRGM COSTS APPRV		0	0	0	0	21.00
23. 00	02300 PARAMED ED PRGM	Ö	0	Ö	0	0	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 (00 540	4 400 //7	0.040.477	4.400	2 200 5/0	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 689, 510	1, 123, 667 0	3, 813, 177	-4, 609 0	3, 808, 568 0	30.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	Ö	Ō	Ö	0	0	1
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	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	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45.00	04500 NURSING FACILITY	0	0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	O	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	7, 183, 990	39, 046, 995	46, 230, 985	-26, 288, 976	19, 942, 009	50.00
51.00	05100 RECOVERY ROOM	2, 174, 815	1, 250, 332			3, 423, 693	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	· · · · · ·	_	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	476, 003	948, 326 513, 064			948, 326 759, 431	
	03630 ULTRA SOUND	470,003	3, 390		·		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
58. 00	05800 MRI		0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	35, 909	484, 873	520, 782	-66	520, 716 0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	52	31, 796	31, 848	0	0 31, 848	
66.00	06600 PHYSI CAL THERAPY	2, 674, 696	896, 002	1		4, 724, 943	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 061, 932	267, 278			0	
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	104, 604	7, 110 31, 809	1		0 32, 711	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	31, 809	32, 711	0	32,711	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 536, 428	1, 536, 428	
72. 00 73. 00	07200 DRUCS CHARGED TO PATIENTS	0	0	0	24, 716, 545	24, 716, 545	
74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S		0		982, 472 0	982, 472 0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77.00	1 1	0	0	0	0	0	
78. 00	O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	1 1	0	0	0	0	0	
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY		0		0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ö				92.00

	THERAN MUSCULOSK				u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	parad.
				10 12/31/2023	5/30/2024 1: 3	
Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cat	Reclassi fi ed	O piii
			+ col . 2)	i ons (See	Trial Balance	
			,	A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS				·		
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	O	o		0 0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	o		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	O	o		0 0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COSTS	ol	ol		0 0	0	98. 00
99. 00 09900 CMHC	O	o		0 0	0	99.00
99. 10 09910 CORF	o	o		0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	o		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	o		0 0	0	101.00
102.00 10200 OPI OID TREATMENT PROGRAM	O	o		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS				<u>.</u>		
105. 00 10500 KI DNEY ACQUI SI TI ON	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		0		0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
116. 00 11600 HOSPI CE	0	0		0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 213, 400	118, 257, 603	142, 471, 00	3 27, 651	142, 498, 654	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192 ON 1920N PHYSICIANS' PRIVATE NEFICES	1 645	20 389	22 03	4 -7 570	14 464	192 00

1, 645

3, 101, 750

27, 316, 795

20, 389

645, 692

118, 923, 684

22, 034

3, 747, 442

146, 240, 479

-7, 570

-20, 081

0

0 193.00

0 194. 01

14, 464 192. 00

3, 727, 361 194. 00

146, 240, 479 200. 00

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS

TOTAL (SUM OF LINES 118 through 199)

194.00 07950 SPORTS MEDICINE

194. 01 07951 SENI OR CIRCLE

200.00

Provider CCN: 15-0168

Period: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm

				5/30/2024 1: 3	ma 8
	Cost Center Description	Adjustments	Net Expenses		-
		(See A-8)	For Allocation		
		6. 00	7.00	_	
	RAL SERVICE COST CENTERS				
	O CAP REL COSTS-BLDG & FIXT	85, 043	4, 081, 449	1	1.00
	O CAP REL COSTS-MVBLE EQUIP O OTHER CAP REL COSTS	104, 179 0	7, 619, 337 0		2. 00 3. 00
1	O EMPLOYEE BENEFITS DEPARTMENT	0	6, 359, 687		4.00
	O ADMINISTRATIVE & GENERAL	-38, 054, 270	17, 042, 353		5.00
7. 00 0070	O OPERATION OF PLANT	0	3, 068, 567		7. 00
	O LAUNDRY & LINEN SERVICE	0	276, 206	l .	8. 00
	O HOUSEKEEPI NG	0	612, 349	l .	9.00
	O DIETARY O MAINTENANCE OF PERSONNEL	0	175, 353 0		10.00 12.00
	O NURSI NG ADMI NI STRATI ON	0	764, 127		13.00
	O CENTRAL SERVICES & SUPPLY	o 0	1, 661, 095		14.00
	O PHARMACY	0	320, 217		15.00
	O MEDICAL RECORDS & LIBRARY	-29	869, 435	5	16.00
	O SOCIAL SERVICE	0	352, 322		17.00
	O OTHER GENERAL SERVICES	0	0		18.00
	O NONPHYSICIAN ANESTHETISTS O NURSING PROGRAM	0	0		19. 00 20. 00
	0 I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
	O I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
	O PARAMED ED PRGM	0	0)	23. 00
	TIENT ROUTINE SERVICE COST CENTERS		0.000.540	, I	
	O ADULTS & PEDIATRICS	0	3, 808, 568		30.00
	O INTENSIVE CARE UNIT O NEONATAL INTENSIVE CARE UNIT	0	0	1	31. 00 31. 01
	O CORONARY CARE UNIT	0	0		32.00
	O BURN INTENSIVE CARE UNIT	Ō	0		33.00
	O SURGICAL INTENSIVE CARE UNIT	0	0		34.00
	O SUBPROVI DER - I PF	0	0		40.00
	O SUBPROVI DER - I RF	0	0		41.00
	O NURSERY O SKILLED NURSING FACILITY	0	0		43. 00 44. 00
	O NURSING FACILITY	0	0		45.00
	O OTHER LONG TERM CARE	Ō	0	1	46.00
	LLARY SERVICE COST CENTERS				
	O OPERATI NG ROOM	0	19, 942, 009		50.00
	O RECOVERY ROOM O DELIVERY ROOM & LABOR ROOM	0	3, 423, 693 0		51. 00 52. 00
	O ANESTHESI OLOGY	-909, 012	39, 314		53.00
	O RADI OLOGY-DI AGNOSTI C	-26, 149	733, 282		54.00
	O ULTRA SOUND	0	3, 390		F 4 04
	O RADI OLOGY-THERAPEUTI C				54.01
56.00 0560		U	0)	55.00
	O RADI OI SOTOPE	0	0	5	55. 00 56. 00
	O RADI OI SOTOPE O CT SCAN	0	0		55. 00 56. 00 57. 00
58. 00 0580	O RADI OI SOTOPE O CT SCAN O MRI	0 0	0 0 0 0		55. 00 56. 00 57. 00 58. 00
58. 00 05800 59. 00 05900	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON	0 0 0	0 0 0 0 0 520, 716	1	55. 00 56. 00 57. 00 58. 00 59. 00
58. 00 05800 59. 00 05900 60. 00 06000	O RADI OI SOTOPE O CT SCAN O MRI		0 0 0 0 0 520, 716		55. 00 56. 00 57. 00 58. 00
58. 00 05800 59. 00 05900 60. 00 06000 60. 01 0600 61. 00 06100	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY	0	520, 716		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00
58. 00 0580 59. 00 0590 60. 00 0600 60. 01 0600 61. 00 0610 62. 00 0620	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL	0	520, 716		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00
58. 00 0580 59. 00 0590 60. 00 0600 60. 01 0600 61. 00 06100 62. 00 0620 63. 00 0630	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS.	0	520, 716		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06400	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY I BLOOD LABORATORY O PBP CLINI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. O I NTRAVENOUS THERAPY	0	520, 716 0 0 0 0 0 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06400 65. 00 06500	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS.	0	520, 716		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00
58. 00 05800 59. 00 05900 60. 00 06000 60. 01 0600 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06400 65. 00 06500 66. 00 06600	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY O BLOOD LABORATORY O PBP CLINI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY	0	520, 716 0 0 0 0 0 0 0 31, 848		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06600 65. 00 06600 67. 00 06700 68. 00 06800	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY 1 BLOOD LABORATORY O PBP CLI NI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. OI NTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY	0	520, 716 0 0 0 0 0 31, 848 4, 724, 943		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00
58. 00 05800 59. 00 05900 60. 00 06600 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06400 65. 00 06500 66. 00 06600 67. 00 06700 68. 00 06800 69. 00 06900	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY 1 BLOOD LABORATORY O PBP CLINI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. OI INTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	520, 716 0 0 0 0 0 31, 848 4, 724, 943		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06400 65. 00 06500 66. 00 06600 67. 00 06800 69. 00 06900 70. 00 07000	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY O PBP CLI NI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDI OLOGY ELECTROCARDI OLOGY	0	520, 716 0 0 0 0 0 31, 848 4, 724, 943 0 32, 711		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06200 63. 00 06300 64. 00 06600 65. 00 06600 66. 00 06600 67. 00 06700 68. 00 06900 70. 00 07000 71. 00 07100	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY O PBP CLI NI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDI OLOGY ELECTROCARDI OLOGY O MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 0 0 0 0 0 0 0	520, 716 0 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06200 63. 00 06200 64. 00 06400 65. 00 06500 66. 00 06600 67. 00 06700 68. 00 06900 70. 00 07100 71. 00 07200	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY O PBP CLI NI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. O I NTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDI OLOGY ELECTROCARDI OLOGY	0	520, 716 0 0 0 0 0 31, 848 4, 724, 943 0 32, 711		55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
58. 00 05800 59. 00 05900 60. 00 06600 61. 00 06200 63. 00 06300 64. 00 06400 65. 00 06500 66. 00 06600 67. 00 06700 70. 00 07000 71. 00 07300 72. 00 07300 74. 00 07400	O RADI OI SOTOPE O CT SCAN O MRI O CARDI AC CATHETERI ZATI ON O LABORATORY 1 BLOOD LABORATORY O PBP CLI NI CAL LAB SERVI CES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORI NG, PROCESSI NG & TRANS. OI NTRAVENOUS THERAPY O RESPI RATORY THERAPY O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY O SPEECH PATHOLOGY O ELECTROENCEPHALOGRAPHY O MEDI CAL SUPPLI ES CHARGED TO PATI ENT OI MPL. DEV. CHARGED TO PATI ENTS O DRUGS CHARGED TO PATI ENTS	0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 64. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00
58. 00 05800 59. 00 05900 60. 00 06600 60. 01 06600 62. 00 06200 63. 00 06500 64. 00 06500 66. 00 06600 67. 00 06700 70. 00 07000 71. 00 07100 72. 00 07300 74. 00 07400 75. 00 07500	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART)	0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 1, 536, 428 24, 716, 545 982, 472		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00
58. 00 05800 59. 00 05900 60. 00 06600 61. 00 06600 62. 00 06200 63. 00 06300 64. 00 06500 65. 00 06500 67. 00 06700 70. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 74. 00 07500 77. 00 07500 77. 00 07700	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY OR RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O ELECTROCARDIOLOGY ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENT OIMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION	0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545 982, 472 0 0		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 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00
58. 00 05800 59. 00 05900 60. 00 06000 61. 00 06100 62. 00 06300 64. 00 06500 65. 00 06500 66. 00 06600 67. 00 06700 70. 00 07700 71. 00 07300 74. 00 07400 75. 00 07500 77. 00 07700 78. 00 07800	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O SPECH PATHOLOGY ELECTROCARDIOLOGY O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY	0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545 982, 472		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00
58. 00	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY I BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O CCUPATIONAL THERAPY O SPEECH PATHOLOGY ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545 982, 472 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00
58. 00	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545 982, 472 0 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00
58. 00	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY I BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O CCUPATIONAL THERAPY O SPEECH PATHOLOGY ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 1, 536, 428 24, 716, 545 982, 472 0 0 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00
58. 00	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O CCUPATIONAL THERAPY O ELECTROCARDIOLOGY O ELECTROCARDIOLOGY O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER	0 0 0 0 0 0 0 0 0 0	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 1, 536, 428 24, 716, 545 982, 472 0 0 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00 79. 00 90. 00 91. 00 91. 00
58. 00	O RADIOISOTOPE O CT SCAN O MRI O CARDIAC CATHETERIZATION O LABORATORY 1 BLOOD LABORATORY O PBP CLINICAL LAB SERVICES-PRGM ONLY O WHOLE BLOOD & PACKED RED BLOOD CELL O BLOOD STORING, PROCESSING & TRANS. O INTRAVENOUS THERAPY O RESPIRATORY THERAPY O PHYSICAL THERAPY O OCCUPATIONAL THERAPY O SPEECH PATHOLOGY O ELECTROCARDIOLOGY O ELECTROENCEPHALOGRAPHY O MEDICAL SUPPLIES CHARGED TO PATIENT O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS O RENAL DIALYSIS O ASC (NON-DISTINCT PART) O ALLOGENEIC HSCT ACQUISITION O CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS O RURAL HEALTH CLINIC O FEDERALLY QUALIFIED HEALTH CENTER	000000000000000000000000000000000000000	520, 716 0 0 0 0 31, 848 4, 724, 943 0 0 32, 711 0 1, 536, 428 24, 716, 545 982, 472 0 0 0 0		55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00 78. 00 79. 00 79. 00 79. 00 71. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00 79. 00 79. 00 79. 00 70. 00 71. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00 79. 00 79. 00

 Heal th Financial
 Systems
 LUTHERAN MUSCULOSKELETAL CENTER

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCM
 Peri od: From 01/01/2023 Provi der CCN: 15-0168 Worksheet A

			To 12/31/2023 Date/Time Pr 5/30/2024 1:	
Cost Center Description	Adjustments	Net Expenses	7 7 007 202 1 11	Piii
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
OTHER REIMBURSABLE COST CENTERS		ما		٠
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	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 99.00 09900 CMHC	0	0		98. 00 99. 00
99. 10 09910 CORF	0	0		99. 00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	O O		100.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	O O		101.00
SPECIAL PURPOSE COST CENTERS	U _I	U		102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	ol	0		105.00
106. 00 10600 HEART ACQUISITION	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		110.00
111. 00 11100 SLET ACQUISITION	o	o		111.00
113.00 11300 I NTEREST EXPENSE	O	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.)	O	О		115.00
116. 00 11600 HOSPI CE	O	o		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-38, 800, 238	103, 698, 416		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	14, 464		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 SPORTS MEDICINE	0	3, 727, 361		194. 00
194. 01 07951 SENI OR CI RCLE	0	0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-38, 800, 238	107, 440, 241		200. 00

					10 12/31/2	5/30/2024	1: 38 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2.00	3. 00	4. 00	5. 00			
1. 00	A - EMPLOYEE BENEFITS	4 00	0	/ 111 10E			1.00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		6, 11 <u>1, 1</u> 85 6, 111, 185			1.00
	B - RENTAL AND LEASE		<u> </u>	0, 111, 100			
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	2, 427, 454			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	735, 882			2.00
3. 00	CAT REE COSTS WINDER EQUIT	0. 00	ő	733, 332			3. 00
4. 00		0. 00	ő	Ö			4.00
5. 00		0. 00	o	Ö			5. 00
6. 00		0.00	o	Ō			6.00
7. 00		0. 00	o	0			7. 00
8. 00		0. 00	o	0			8. 00
9. 00		0. 00	O	0			9. 00
10.00		0. 00	O	0			10.00
11.00		0. 00	0	0			11.00
12.00		0. 00	0	0			12.00
				3, 163, 336			1
	C - OTHER CAPITAL COST			·			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	198, 186			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	591, 260			2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	<u>1, 1</u> 47			3.00
	0		0	790, 593			
	D - REPAIRS & MAINTENANCE						
1.00	OPERATION OF PLANT	7. 00	0	1, 052, 975			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. 00	0	0			10.00
11. 00 12. 00		0.00	0	0			11. 00 12. 00
13.00		0.00	0	0			13.00
14. 00		0.00	0	0			14.00
14.00				1, 052, 975			14.00
	E - CHIEF NURSING OFFICER		<u> </u>	1,032,773			
1.00	NURSI NG ADMI NI STRATI ON	13. 00	262, 410	0			1.00
	0		262, 410	$ \frac{0}{0}$			
	F - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 536, 428			1.00
	PATI ENT			, ,			
2.00	IMPL. DEV. CHARGED TO	72. 00	O	24, 716, 545			2.00
	PATI ENTS						
3.00		0. 00	0	0			3.00
	0		0	26, 252, 973			
	G - DRUGS/IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	7300	0_	98 <u>2, 4</u> 72			1.00
	0		0	982, 472			
	H - MISC DEPTS						
1. 00	PHYSI CAL THERAPY	66. 00	1, 166, 536	219, 162			1.00
2. 00		0.00	•	0			2. 00
-a	0		1, 166, 536	219, 162			
500.00	Grand Total: Increases		1, 428, 946	38, 572, 696			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0168

						To 12/31/2023 Date	/IIme Prepared: /2024 1:38 pm
		Decreases				1 37 30	7 2024 1. 30 piii
	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	5. 00	0	<u>6, 111, 1</u> 85	s c		1. 00
	0		0	6, 111, 185	5		
	B - RENTAL AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 242, 487			1.00
2.00	OPERATION OF PLANT	7. 00	0	726			2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	144			3.00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	55, 407			4.00
5.00	MEDICAL RECORDS & LIBRARY	16. 00	0	7, 795	5 0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	5	5 C		6. 00
7.00	OPERATING ROOM	50.00	0	427, 038	3 C		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	213, 538	3 C		8.00
9.00	PHYSI CAL THERAPY	66. 00	0	156, 377	' C		9. 00
10.00	OCCUPATI ONAL THERAPY	67. 00	0	45, 300	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	30	0		11. 00
12.00	SPORTS MEDICINE	194. 00	0	14, 489	<u> </u>		12.00
	0		0	3, 163, 336			
	C - OTHER CAPITAL COST						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	790, 593			1.00
2.00		0. 00	0	0			2. 00
3.00		0. 00	0	0)12	2	3.00
	0		0	790, 593	3		
	D - REPAIRS & MAINTENANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	95			1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	394, 000	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	5, 773			3.00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	42, 811	C		4. 00
5.00	PHARMACY	15. 00	0	17, 685	5 0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	4, 604	· C		6. 00
7.00	OPERATING ROOM	50. 00	0	480, 314	· C		7. 00
8.00	RECOVERY ROOM	51. 00	0	1, 454	· C		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 098	3		9. 00
10.00	LABORATORY	60.00	0	66	C		10.00
11.00	PHYSI CAL THERAPY	66. 00	0	67, 017	ď		11. 00
12.00	OCCUPATI ONAL THERAPY	67. 00	0	9, 926	o C		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	7, 540	0		13.00
14.00	SPORTS MEDICINE	194. 00	0	5, 592	2		14.00
	0		0	1, 052, 975	5		
	E - CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5. 00	262, 410	0			1.00
	0		262, 410				
	F - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	25, 381, 624	C		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	863, 290	0		2. 00
3.00	PHYSI CAL THERAPY	66. 00	0	8, 059) c		3.00
	0 — — — — —	- $ -$		26, 252, 973	3		
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15. 00	0	982, 472	2 C		1.00
		- $ -$		982, 472	2		
	H - MISC DEPTS		<u>'</u>				
1.00	OCCUPATI ONAL THERAPY	67. 00	1, 061, 932	212, 052	2 C		1.00
2.00	SPEECH PATHOLOGY	6800	104, 604	7, 110) C		2.00
	0		1, 166, 536	219, 162			
500.00	Grand Total: Decreases		1, 428, 946	38, 572, 696			500.00
	'						•

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

					To 12/31/2023	Date/Time Pre	
				A : - : - : - : - : - : - : - : -		5/30/2024 1: 3	8 pm
		B	D	Acqui si ti ons		D'	
		Begi nni ng	Purchases	Donati on	Total	Disposals and Retirements	
		Bal ances 1, 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	3.00	4.00	5.00	
1. 00	Land	I DALANCES	ما		0 0	0	1. 00
2. 00	Land Improvements	26, 765	0		0	0	2.00
3. 00	Buildings and Fixtures	865, 378	57, 704		0 57, 704	0	3.00
4. 00	Building Improvements	8, 396, 966	349, 248		0 349, 248		4. 00
5. 00	Fixed Equipment	2, 363, 333	211, 322		0 211, 322	•	5.00
6. 00	Movable Equipment	23, 286, 430	4, 435, 616		0 4, 435, 616		6.00
7. 00	HIT designated Assets	13, 366	23, 508		0 4, 435, 616	•	7. 00
8. 00	Subtotal (sum of lines 1-7)	34, 952, 238	5, 077, 398		0 5, 077, 398		8.00
9. 00	Reconciling Items	34, 932, 230	5, 077, 396		0 3,077,396	757, 761	9.00
10.00	Total (line 8 minus line 9)	34, 952, 238	5, 077, 398		0 5 077 398	Ĭ	9. 00 10. 00
10.00	Total (Tine 8 minus Tine 9)	34, 952, 238 Endi ng	5, 077, 398 Fully		0 5, 077, 398	757, 781	10.00
		Bal ance	Depreciated				
		bai ance	Assets				
		6. 00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		7.00				
1. 00	Land	DALANCES	0				1. 00
2. 00		26, 765	0				2.00
3. 00	Land Improvements Buildings and Fixtures	923, 082	0				3.00
4. 00	Building Improvements	8, 205, 198	0				4. 00
5. 00	Fixed Equipment	2, 574, 655	0				5.00
6. 00			0				6.00
7. 00	Movable Equipment HIT designated Assets	27, 505, 658 36, 497	0				7.00
8. 00	Subtotal (sum of lines 1-7)		0				8.00
9. 00	Reconciling Items	39, 271, 855	0				9.00
10.00		39, 271, 855	0				9. 00 10. 00
10.00	Total (line 8 minus line 9)	39, 211, 855	υĮ				10.00

Heal th	Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	?	In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0168	Peri od: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00	CAP REL COSTS-BLDG & FLXT	779, 506	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 778, 129	l e		0	0	2.00
3.00	Total (sum of lines 1-2)	7, 557, 635	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	779, 506				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 778, 129				2.00
3.00	Total (sum of lines 1-2)	0	7, 557, 635				3.00

Heal th	n Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	?	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023 Fo 12/31/2023	Worksheet A-7 Part III Date/Time Pre 5/30/2024 1:3	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2, 00	col . 2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	9, 155, 045	0	9, 155, 04	0. 233120	0	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	30, 116, 810					2. 00
3. 00	Total (sum of lines 1-2)	39, 271, 855		39, 271, 85			3. 00
ALLOCATION O					SUMMARY 0		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
		6. 00	ed Costs 7.00	through 7) 8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	8.00	9.00	10.00	
1. 00	CAP REL COSTS-BLDG & FLXT	0	0		864, 549	2, 427, 454	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		6, 882, 308		2. 00
3. 00	Total (sum of lines 1-2)	0	Ö		7, 746, 857		3. 00
	,		SL	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	198, 186	591, 26	0	4, 081, 449	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	· ·		0	7, 619, 337	2.00
3.00	Total (sum of lines 1-2)	0	199, 333	591, 26	0	11, 700, 786	3.00
			-	-		•	

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 OADMINISTRATIVE & GENERAL 5 00 7.00 stations excluded) (chapter 8.00 Television and radio service -9, 278 ADMINISTRATIVE & GENERAL 5.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physici an -967, 430 10.00 A - 8 - 2adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 -2.114.427 transactions (chapter 10) 13.00 Laundry and linen service 0 0.00 13.00 Cafeteria-employees and guests 14.00 0 0.00 14.00 15.00 Rental of quarters to employee 0 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 -29 MEDICAL RECORDS & LIBRARY R 16.00 18.00 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366.00 therapy costs in excess of limitation (chapter 14) Utilization review OUTILIZATION REVIEW-SNF 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

-38, 800, 238

-621, 250 ADMINISTRATIVE & GENERAL

-669 ADMINISTRATIVE & GENERAL

-3, 944 ADMINISTRATIVE & GENERAL

-33, 443, 985 ADMI NI STRATI VE & GENERAL

5.00

5.00

5.00

5.00

0.00

o 38.00

39.00

40.00

41.00

42.00

50.00

Α

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

OTHER ADJUSTMENTS (SPECIFY)

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

PHYSICIAN RECRUITING

MINORITY INTEREST

PENALTI ES

LEGAL FEES

38. 00

39.00

40.00

41.00

42.00

50.00

⁽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: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: OFFICE COSTS

				12,01,2020	5/30/2024 1: 3	
	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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	0.00			o	o	2.00
3.00	0.00			O	o	3.00
3. 01	0.00			0	0	3. 01
3. 02	0.00			o	0	3.02
3. 03	0.00			0	0	3. 03
3. 04	0.00			0	0	3. 04
3. 05	0.00	l .		0	0	3. 05
3. 06	0.00			0	0	3. 06
3. 07	0.00			0	0	3. 07
3. 08	0.00			0	0	3. 08
3. 09	0.00	l .		0	0	3. 09
3. 10	0.00			0	0	3. 10
3. 11	0.00			o	0	3. 11
3. 12	0.00			0	0	3. 12
3. 13	0.00			o	0	3. 13
3. 14	0.00			o	0	3. 14
3. 15	0.00			o	0	3. 15
3. 16	0.00		CONTRACT MANAGEMENT	o	0	3. 16
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	312	o	4.00
4. 01		CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	669	o	4.01
4. 02	5. 00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	196, 366	226, 630	4.02
4.03	5. 00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca		1, 073, 347	4.03
4.04		CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix		0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	117, 027	o	4.05
4.06		ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	3, 174, 784	0	4.06
4.07	5. 00	ADMINISTRATIVE & GENERAL	Mal practice Costs	28, 860	196, 968	4.07
4. 08	5. 00	ADMINISTRATIVE & GENERAL	Management Fees	o	3, 859, 260	4.08
4. 09	5. 00	ADMINISTRATIVE & GENERAL	401K Fees	o	5, 151	4.09
4. 10	5.00	ADMINISTRATIVE & GENERAL	Audit Fees	0	104, 634	4. 10
4. 11		ADMINISTRATIVE & GENERAL	Corporate Overhead Allocatio	0	2, 278, 852	4. 11
4. 12			HIIM Allocation	l ol	410, 364	4. 12
4. 13		ADMINISTRATIVE & GENERAL	Contract Management	l ol	144, 461	4. 13
4. 14		ADMINISTRATIVE & GENERAL	PASI Lien Unit Collection Fe	l ol	-46, 021	4. 14
5. 00	TOTALS (sum of lines 1-4).			6, 139, 219	8, 253, 646	5. 00
	Transfer column 6, line 5 to				2, 222, 0.0	2.20
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

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:				

Heal th	Financial Systems	LUTHERAN MUSCULO	OSKELETAL CENTE	ER	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-0168	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
				Related Orga	nization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	1	Vame	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	4. 00	5. 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

					10 12/31/2023	5/30/2024 1:3	epared: 38 nm
	Net	Wkst. A-7 Ref.				37 307 2024 1. 0) piii
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED (ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	0	0					1.00
2.00	0	0					2.00
3.00	0	0					3.00
3. 01	0	0					3. 01
3.02	0	0					3. 02
3.03	0	0					3.03
3.04	0	0					3.04
3.05	0	0					3.05
3.06	0	0					3.06
3.07	0	0					3.07
3.08	0	0					3. 08
3.09	0	0					3.09
3. 10	0	0					3. 10
3. 11	0						3. 11
3. 12	0						3. 12
3. 13	0						3. 13
3. 14	0						3. 14
3. 15	0						3. 15
3. 16	0						3. 16
4.00	312						4.00
4. 01	669						4. 01
4. 02	-30, 264						4. 02
4.03	1, 463, 123						4. 03
4.04	84, 731						4. 04
4.05	117, 027						4. 05
4.06	3, 174, 784						4. 06
4.07	-168, 108						4. 07
4. 08	-3, 859, 260						4. 08
4. 09	-5, 151						4. 09
4. 10	-104, 634						4. 10
4. 11	-2, 278, 852						4. 11
4. 12	-410, 364						4. 12
4. 13	-144, 461						4. 13
4. 14	46, 021						4. 14
5.00	-2, 114, 427						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.

nas no	been posted to norksheet A,	corumns r ana, or 2,	, the amount	arrowabre	Should be	, i nai catca i	ii corumii i	or this part	•
	Related Organization(s)								
	and/or Home Office								
	Type of Business								
	6. 00								
	D INTERDELATIONSHIP TO DELA	TED ODCANI ZATION(S)	AND/OD HOME	OEELCE:					
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

Termbur sement under titte xviii.							
6.00	HEALTHCARE		6.00				
	HEALTHCARE		7.00				
	HEALTHCARE		8.00				
9.00			9.00				
10.00			10.00				
100.00		1	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.

					'	12/31/2023	5/30/2024 1:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JO DIII
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	38, 982	25, 087	13, 895	179, 000	78	1. 00
2.00	53. 00	ANESTHESI OLOGY	909, 012	909, 012	0	0	0	2.00
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	26, 149	26, 149	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			974, 143		13, 895			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	6, 713		0	0	0	1.00
2.00		ANESTHESI OLOGY	0	0	0	0	0	2. 00
3.00		RADI OLOGY-DI AGNOSTI C	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	
8. 00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	
10.00	0. 00		4 712	224	0	0	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	6, 713 Provi der	336 Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillen t		
		rdentiffer	Share of col.	LIIIII	DI Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	0	6, 713	7, 182	32, 269		1. 00
2. 00		ANESTHESI OLOGY	0	0	0	909, 012		2.00
3. 00		RADI OLOGY-DI AGNOSTI C	0	Ō	0	26, 149		3. 00
4. 00	0. 00		0	0	0	0		4.00
5. 00	0. 00		0	Ō	0	Ö		5. 00
6. 00	0. 00		0	0	0	Ō		6. 00
7. 00	0. 00		0	0	0	0		7.00
8. 00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	6, 713	7, 182	967, 430		200.00
·			•					

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0168

Not Depote Secretary Description Not Depote Secretary Description Not Depote Secretary Description Not Depote Secretary Description Secretary Depote Secretary Depot					To	12/31/2023	Date/Time Pre 5/30/2024 1:3	
TOP COST C				CAPI TAL REI	ATED COSTS		3/30/2024 1.3	o piii
AFF Cost Cost Centres Centres Centres Cost Centres Centr		Oct I Oct I con December 1	No. 1. E	DI DO A FLYT	AN/DIE FOULD	EMPL OVEE	6 1 1 1 1 1	
CEMBRAL SERVICE COST CENTERS		Cost Center Description		BLDG & FIXI	MVBLE EQUIP	-	Subtotal	
CEREMAL SERVICE COST CERTIENS						52.7		
Control Cont								
1.00		CENEDAL SEDVICE COST CENTEDS	0	1.00	2.00	4. 00	4A	
2.00 00000 CAP REL DOSTS-MYRILE EQUIP 7, 619, 337 7, 619, 337 0, 359, 687 18, 644, 013 5.00 6	1. 00		4. 081. 449	4, 081, 449				1.00
5.00 DODOD ARMIN INSTRATIVE & GENERAL 17, 042, 353 94, 790 176, 950 24, 193 18, 644, 071 5, 00 000 000 000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 0000 270, 255 800 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000		l l						
7. 00 00 0000 DEPEATION OF PLANT 3.08,857 533,201 995,399 24,199 4,671,319 7.00 8.00 276,206 8.00 276,206 8.00 9.00 0.00 253,200 8.00 9.00 0.00 253,200 9.00 0.00 256,200 8.00 9.00 0.00 256,200 8.00 9.00 1.00 2.00 120,00 100 1.00								
B.OD ODSOOL JAURDRY & LINEN SERVICE 276, 200 O O C 253 612, 620 0.0				l '				
0.000 0.0000 DUISEXEEP ING			1				• •	
12.00 01200/MINITERINANCE OF PERSONNEL 0 0 0 164,152 798,277 13.00 13.00 1300/MINISH ADMINISTRATION 764,127 13.00 13.00 1300/MINISH ADMINISTRATION 764,127 13.00 13.00 13.500			1	l e		-	· ·	
13.00 01300 MURSH NO ADMINI STRATION 764, 127 0 0 164, 152 928, 279 13.00 15.00 01500 PARAMACY 320, 217 34.113 290, 366 135, 509 2,116, 1082 14.00 15.00 01500 PARAMACY 320, 217 34.113 290, 366 135, 509 2,116, 1082 14.00 15.00 01500 PARAMACY 320, 217 34.113 290, 366 135, 509 2,116, 108 15.00 01500 PARAMACY 320, 217 34.113 290, 366 135, 509 2,116, 108 15.00 01500 DTER GENRAL SERVICES 352, 222 0 0 0 0 0 0 15.00 01500 OTHER GENRAL SERVICES 352, 222 0 0 0 0 0 0 15.00 01500 OTHER GENRAL SERVICES 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 0 15.00 02000 MURSH NO REPORTAL SERVICES 0 0 0 0 0 0 0 0 0			175, 353	0	0	35	175, 388	
14.00 01400 CENTRAL SERVICES & SUPPLY 1. 661.095 134, 113 259.365 335, 560 2, 181, 082 14. 00 16.00 01600 MEDICAL RECORDS & LIBRARY 809, 435 0 0 0 12, 930 882, 261 16.00 17.00 1700 0			0	0	0	-		
15.00 01500 PHABMACY 320, 217			1	0 137 113	250 365			
16.00 01000 MEDI CAL RECORDS & LIBRARY 869, 435 0 0 12, 930 882, 365 16.00 18.00 01800 OTHER CERNRAL SERVICES 0 0 0 0 0 0 0 18.00 01800 OTHER CERNRAL SERVICES 0 0 0 0 0 0 0 20.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 20.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 21.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 22.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 0 23.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 0 23.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 0 23.00 02000 MINESTREY PROCESSA 0 0 0 0 0 0 0 0 0								
18. 00 01800 01HER CENERAL SERVICES 0 0 0 0 0 0 0 18 00			1	0	0			
19.00 1900 NOMPHYSICI AN AMESINETISTS 0 0 0 0 0 0 20 00 21 00 22 00 2200 0200 UNESIN OPENCIAN A FRINGES APPRV 0 0 0 0 0 0 0 22 00 2200 2200 0200 LARS SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22 00 2200 23 00 0 0 0 0 0 0 0 0			352, 322	0	0	76, 612		
20.00 20.00 20.00 20.00 3.00 0 0 0 0 0 0 0 22.00			0	0	0	0		
21.00 2020 BAR SERVICES-SALARY & FENNES APPRY 0 0 0 0 0 0 22.00 2020 18A SERVICES-CONTER PREMIC OSTS APPRY 0 0 0 0 0 0 22.00 2020 2020 2020 2020 18A SERVICES-CONTER PREMICE OSTS APPRY 0 0 0 0 0 0 22.00 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 2020 202			0	0	0	0	_	
23.00 02300 PARAMED ED PROM			0	Ö	Ö	0	_	
INPATI ENT ROUTI NE SERVICE COST CENTERS 3,808,568 326,146 608,857 627,447 5,371,018 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.			0	0	0	0		
30.00 30000 ADULTS & PEDIATRICS 3,808,568 326,146 608,857 627,447 5,371,018 30.00 31.01 31.00 31.01 31.00 31.01 32.00 32.00 32.00 32.00 32.00 33.00 34.00	23. 00		0	0	0	0	0	23. 00
31.00 03100 INTENSIVE CARE UNIT	30 00		3 808 568	326 146	608 857	627 117	5 371 018	30 00
31.01 02660 NEONATAL INTENSIVE CARE UNIT			0,000,300					
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0			0	0	0	0	_	
40.00 04000 SUBPROVI DER - I PF			0	0	0	0		
1.00 04100 04100 04100 0 0 0 0 0 0 0 0 0			0	0	0	0	_	
44 00 04400 SALLED NURSING FACILITY			0	Ö	Ö	0	0	
45.00 04500 NURSI NG FACILLITY			0	0	0	0	_	
Accordance Acc			0	0	0	0	_	
ANCILLARY SERVICE COST CENTERS			0	0		0	_	•
51.00 05100 RECOVERY ROOM 3,423,693 200,533 374,359 507,371 4,505,956 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	.0.00				<u> </u>	<u>_</u>		10.00
S2.00 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05400 0550								
53.00 05300 AMESTHESI OLOGY 39, 314 0 0 0 39, 314 53.00								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 733, 282 110, 972 207, 165 111, 049 1, 162, 468 54. 01 54. 01 03530 ULTRA SOUND 3, 390 0 0 0 0 3, 390 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 57. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 56. 00 58. 00 05800 MRI 0 0 0 0 0 0 0 0 58. 00 59. 00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 0 59. 00 60. 01 06000 BADGRATORY 520,716 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td>1</td> <td>1</td> <td></td> <td>_</td> <td></td> <td></td>			1	1		_		
55.00 05500 RADI OLGY-THERAPEUTI C 0 0 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 0 57.00 58.00 05800 MRI 0 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0			1	l	207, 165	111, 049		
56. 00			3, 390	0	0	0		
57.00 05700 CT SCAN 0 0 0 0 0 0 0 57.00			0	0	0	0		
58. 00 05800 MRI 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHERERIZATION 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 520,716 0 0 0 8,377 529,093 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 60. 01 61. 00 06200 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 06200 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 62. 00 64. 00 06400 NATIVE ONLY THERAPY 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>_</td> <td></td>			0	0	0	0	_	
60. 00 06000 LABORATORY 520, 716 0 0 0 8, 377 529, 093 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0			0	Ö	Ö	0	_	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0			0	0	0	0		•
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0			520, 716	0	0	8, 377		•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 62.00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 31,848 0 0 12 31,860 65.00 66.00 06600 PHYSI CAL THERAPY 4,724,943 659,043 1,230,315 896,136 7,510,437 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 32,711 0 0 210 32,921 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1,536,428 0 0 0 0 24,716,545 73.00 07300 DRUGS CHARGED TO PATI ENTS 982,472 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINI C 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 80.00 08900 FEDERALLY QUALIFIED H			0	0	l 0	U		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63. 00 64. 00 64.00 1NTRAVENOUS THERAPY 0 0 0 0 0 0 0 64.00 65.00 665.00 665.00 665.00 665.00 665.00 665.00 665.00 665.00 665.00 665.00 685.00		1 1	0	0	o	0	_	•
65. 00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	_	63. 00
66. 00 06600 PHYSI CAL THERAPY 4,724,943 659,043 1,230,315 896,136 7,510,437 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 32,711 0 0 0 210 32,921 69. 00 070. 00 07000 ELECTROECEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		1	0	0	0	0		•
67. 00		l l	1	ł	1 230 215			•
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 32, 711 0 0 0 210 32, 921 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 536, 428 0 0 0 0 1, 536, 428 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 24, 716, 545 0 0 0 0 24, 716, 545 73. 00 07300 DRUGS CHARGED TO PATI ENTS 982, 472 0 0 0 0 982, 472 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 00 0 0 0 0 00 0			4, 724, 743	037,043	1, 230, 313	0, 130		•
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 1,536,428 0 0 0 1,536,428 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 24,716,545 0 0 0 24,716,545 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 982,472 0 0 0 982,472 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 00TPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 70. 00 0 0 0 0 0 70. 00 0 0 0 0 70. 00 0 0 0 0 80. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 80. 00 00 0 0 0 80. 00 00 0 0 80. 00 00 0 0 80. 00 00 0 80. 00 00 0 80. 00 00 0 80. 00 00 0 80. 00 00 0 80. 00 00 0 80. 00 00 0 80. 00 00 00 80. 00 00 00 80. 00 00 80. 00 00 80. 00 00 80. 00 00 80. 00 8			0	0	0	0	0	•
71. 00			32, 711	0	0			•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 716, 545 0 0 0 24, 716, 545 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 982, 472 0 0 0 982, 472 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 00TPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 982, 472 73. 00 0 0 0 0 74. 00 0 0 0 0 75. 00 0 0 0 0 76. 00 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 0 0 0 89. 00 0 0 0 89. 00 0 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0 89. 00 0 0 89. 00 0 0 89. 00 0 0 89. 00 0			1 524 420	0	0	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 982, 472 0 0 0 982, 472 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 78. 00 00179ATIENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 89. 00 08900			1	l e		0		•
75. 00 07500 ASC (NON-DISTINCT PART)			1	l e	0	0		
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 78. 00 00 00 00 00 00 00 00			0	0	0	0		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00			0	0	0	0	_	
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00			0	0		-		
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00	, 5. 55			·	·	<u> </u>	0	, 5. 55
		08800 RURAL HEALTH CLINIC	0			-	_	
<u>40. 00 04000 0611010 0 0 0 0 90. 00</u>			0	1		-	_	
	70.00	03000 CE1 N1 C	1 0	1 0	ı U	U	0	70.00

			To	o 12/31/2023	Date/Time Pro	
		CAPI TAL REI	ATED COSTS		5/30/2024 1:3	38 pm
		CAPITAL REL	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
cost center bescription	for Cost	DLDO & TIXI	WVDLL LQUIT	BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A			DEI AIKTIMEINT		
	col. 7)					
	0	1. 00	2.00	4. 00	4A	
91. 00 09100 EMERGENCY	0	1.00				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	ı .	O	o o	ŏ	(
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	O	C	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	o o	0	C	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	o o	0	C	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		
98. 00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	C	
99. 00 09900 CMHC	0	0	0	0	(
99. 10 09910 CORF	0	0	0	0		1
100.00 10000 &R SERVICES-NOT APPRVD PRGM	0	0	0	0	_	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		0	<u> </u>		1102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	o o	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	o o	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0	0	0		111.00
113. 00 11300 NTEREST EXPENSE	-	_		-	_	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	(115.00
116, 00 11600 HOSPI CE	0	0	0	o		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	103, 698, 416	3, 135, 450	5, 853, 325	5, 635, 683	100, 262, 401	118.00
NONREI MBURSABLE COST CENTERS	,			., ,	, , , , , , , , , , , , , , , , , , , ,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	C	190. 00
191. 00 19100 RESEARCH	0	0	0	o	C	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	14, 464	945, 999	1, 766, 012	384	2, 726, 859	192.00
193.00 19300 NONPALD WORKERS	0	0	0	o	C	193. 00
194.00 07950 SPORTS MEDICINE	3, 727, 361	0	0	723, 620	4, 450, 981	194.00
194. 01 07951 SENI OR CIRCLE	o	0	0	o		194. 01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	o	o	C	201.00
202.00 TOTAL (sum lines 118 through 201)	107, 440, 241	4, 081, 449	7, 619, 337	6, 359, 687	107, 440, 241	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm

				'		5/30/2024 1: 3	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	7.00	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 ADMINISTRATIVE & GENERAL	18, 644, 012					5. 00
7. 00	00700 OPERATION OF PLANT	970, 311	5, 591, 630	1			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	57, 993	0	334, 199			8.00
9.00	00900 HOUSEKEEPI NG	128, 624 36, 825	0		741, 226	212 212	9.00
10. 00 12. 00	01000 DIETARY 01200 MAINTENANCE OF PERSONNEL	30, 825	0		0	212, 213 0	10.00 12.00
13. 00	01300 NURSING ADMINISTRATION	194, 905	0		0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	457, 949	217, 148	0	28, 785	0	14.00
15. 00	01500 PHARMACY	80, 993	0		0	ő	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	185, 265	0	O	0	0	16.00
17.00	01700 SOCIAL SERVICE	90, 061	0	0	0	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 127, 720	528, 076	198, 638	70, 002	212, 213	30.00
	03100 NTENSI VE CARE UNI T	1, 127, 720	320,070	170,030	70,002	0	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	Ö	0	0	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	Ö	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	l o	0	Ö	o	ő	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	O	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	44.00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS	E 107 070	1 742 240	105 5/1	221 005	0	FO 00
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	5, 187, 070 946, 089	1, 743, 249 324, 691	135, 561 0	231, 085 43, 041	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	940, 089	324, 091	1	43, 041	0	52.00
53. 00	05300 ANESTHESI OLOGY	8, 255	0	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	244, 076	179, 679	Ö	23, 818	ő	54.00
54. 01	03630 ULTRA SOUND	712	0	ō	0	Ō	54. 01
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	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	111, 090	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	6, 689	0	0	0	Ő	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 576, 921	1, 067, 082	l ő	141, 452	ő	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	O	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	6, 912	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	322, 595	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 189, 585	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	206, 284	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	ı ₁ 0	0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC		^	^	ما	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	ام	0	1
90.00	09000 CLINIC		0	0	l o	0	
91.00	09100 EMERGENCY		n	l o	n	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS]
94.00	09400 HOME PROGRAM DIALYSIS	0	0	l .			
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00

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

			To	12/31/2023	Date/Time Prepared: 5/30/2024 1:38 pm
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
5551 551161 55551 Pt 1 511	E & GENERAL	PLANT	LINEN SERVICE	HOUGENEEL THE	5.2.7
	5. 00	7. 00	8. 00	9. 00	10.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0 97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	0 98.00
99. 00 09900 CMHC	0	0	0	0	0 99.00
99. 10 09910 CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0 105.00
106. 00 10600 HEART 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 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0	0	0	0	0 116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 136, 924	4, 059, 925	334, 199	538, 183	212, 213 118. 00
NONREI MBURSABLE COST CENTERS				ما	2100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191. 00 19100 RESEARCH	F72 F42	1 521 705	0	202 042	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	572, 542	1, 531, 705	0	203, 043	0 192.00
193. 00 19300 NONPALD WORKERS	024 546	0	0	0	0 193.00
194. 00 07950 SPORTS MEDI CI NE 194. 01 07951 SENI OR CI RCLE	934, 546	0	0	U	0 194. 00 0 194. 01
	0	0	U	٩	200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		_			0 201.00
202.00 Regative cost centers 202.00 TOTAL (sum lines 118 through 201)	18, 644, 012	5, 591, 630	224 100	741, 226	•
202.00 TOTAL (Suill TITIES TT8 ETITOUGH 201)	10, 044, 012	J 5, 591, 630	334, 199	741, 220	212, 213 202. 00

			10) 12/31/2023	Date/lime Pre 5/30/2024 1:3	
Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	OF PERSONNEL	ADMI NI STRATI O N	SERVI CES & SUPPLY		RECORDS & LI BRARY	
	12. 00	13. 00	14. 00	15.00	16.00	
GENERAL SERVICE COST CENTERS	T T					4 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI 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 10. 00 01000 DI ETARY						9.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0					10. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	l o	1, 123, 184				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	2, 884, 964			14.00
15. 00 01500 PHARMACY	0	0	0	466, 738		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	1, 067, 630	16.00
17. 00 01700 SOCI AL SERVI CE 18. 00 01850 OTHER GENERAL SERVI CES		0	0	0	0	17. 00 18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	l ő	0	0	0	Ö	19.00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l ol	U	U	0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	O	305, 822	22, 193	0	15, 225	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31. 01
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF		0	Ö	0	Ö	40.00
41. 00 04100 SUBPROVI DER - RF	o	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44. 00 04400 SKI LLED NURSI NG FACILITY	0	0	0	0	0	44.00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS	<u> </u>	J	U _I	0	0	40.00
50. 00 05000 OPERATING ROOM	0	536, 473	935, 066	0	309, 685	50.00
51. 00 05100 RECOVERY ROOM	0	279, 081	0	0	,	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0	2 450	0	20.224	52. 00 53. 00
54. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	300	2, 450 0	0	29, 336 27, 600	54.00
54. 01 03630 ULTRA SOUND		0	0	0	16	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	O	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	58. 00 59. 00
60. 00 06000 LABORATORY		1, 382	6, 930	0	13, 761	
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_	_	_	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00
64.00 06400 NTRAVENOUS THERAPY		0	0	0		63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	l o	Ö	0	0	641	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	10, 528	0	56, 100	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	124	0	0	0	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		126	0	0	2, 263	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l o	Ö	103, 682	0	68, 133	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 791, 968	0	434, 118	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	466, 738		73.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	82	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	0	75. 00 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	-		-	_	_	
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0	0	0	0	90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		U	U	U		91.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
					<u>-</u>	

| Peri od: | Worksheet B | From 01/01/2023 | Part I | To | 12/31/2023 | Date/Time Prepared:

			10	12/31/2023	5/30/2024 1: 38 pm
Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
	OF PERSONNEL	ADMI NI STRATI O	SERVICES &		RECORDS &
		N	SUPPLY		LI BRARY
	12. 00	13. 00	14.00	15.00	16. 00
95. 00 09500 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
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
102.00 10200 OPI OID TREATMENT PROGRAM	0	0	0	0	0 102.00
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, 123, 184	2, 872, 817	466, 738	1, 067, 630 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	8	0	0 192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 SPORTS MEDICINE	0	0	12, 139	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	0	0	0	o	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	1, 123, 184	2, 884, 964	466, 738	1, 067, 630 202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168

				To	12/31/2023	Date/Time Pre 5/30/2024 1:3	
			OTHER GENERAL			INTERNS &	<u> Б</u>
	Cost Center Description	SOCI AL	SERVI CE S	NONPHYSI CI AN	NURSI NG	RESI DENTS SERVI CES-SALA	
		SERVI CE		ANESTHETI STS	PROGRAM	RY & FRINGES	
		17. 00	18. 00	19. 00	20. 00	APPRV 21. 00	
	GENERAL SERVICE COST CENTERS	17.00	10.00	17.00	20.00	21.00	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT						1. 00 2. 00
4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT						7.00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10. 00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	518, 995					16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICES	0 310, 993	0				18.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0			19. 00
20.00	02000 NURSI NG PROGRAM	0	0		0		20.00
21. 00 22. 00	02100 1 & R SERVICES-SALARY & FRINGES APPRV 02200 1 & R SERVICES-OTHER PRGM COSTS APPRV	0				0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	Ö	Ö				23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	E10, 00E	1 0			0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	518, 995 0	0		0		30. 00 31. 00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	Ö	Ö	0	0	0	31. 01
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF	Ö	Ö	Ö	0	0	40. 00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	Ö	Ö	Ö	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	Ö	Ö		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	·	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	0	0	53. 00 54. 00
54. 01	03630 ULTRA SOUND	0	Ö	Ö	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
	05800 MRI	0	Ö	Ö	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	0	0	0	60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ĭ		O		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0 0	63. 00 64. 00
65. 00	1 1	0	Ö	0	0	0	65.00
66. 00		0	0	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0 0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	O	0	0	74.00
75. 00 77. 00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	75. 00 77. 00
	07700 ALLOGENETC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY				0		77.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0 0	0	89. 00 90. 00
91.00	09100 EMERGENCY	Ö	Ö	o	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	<u> </u>				92.00

			To	12/31/2023	Date/Time Pre 5/30/2024 1:3	
		OTHER GENERAL			I NTERNS &	, piii
		SERVI CE			RESI DENTS	
Cost Center Description	SOCI AL	S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	
	SERVI CE		ANESTHETI STS	PROGRAM	RY & FRINGES	
					APPRV	
	17. 00	18. 00	19. 00	20. 00	21. 00	
OTHER REIMBURSABLE COST CENTERS	T					
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	_	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
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	1 , , , , , ,
99. 10 09910 CORF	0	0	0	0	0	1 , , , , , ,
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS			_		_	
105. 00 10500 KI DNEY ACQUI SI TI ON	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	1	107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0	0	0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_ [_	_	_	_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	_	0	_	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	518, 995	0	0	0	0	118.00
NONREI MBURSABLE COST CENTERS						100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	•	192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	•	193.00
194. 00 07950 SPORTS MEDICINE	0	0	0	0		194.00
194. 01 07951 SENI OR CI RCLE	0	0	0	0		194. 01
200.00 Cross Foot Adjustments		^		0		200.00
201.00 Negative Cost Centers	E10 005	0	_	0		201.00
202.00 TOTAL (sum lines 118 through 201)	518, 995	0	0	0	1 0	202. 00

Cost Center Description		•	JTHERAN MUSCULOS				u of Form CMS-2	2552-10
Cost Center Description	CUST	ALLUCATION - GENERAL SERVICE COSTS		Provider C		rom 01/01/2023	Worksheet B Part I	
Cost Center Description					Τ	o 12/31/2023	Date/Time Pre	pared:
Cost Center Rescription			INTEDNS &				5/30/2024 1: 3	8 pm
Description Services Description Services Price Pric								
APPROV		Cost Center Description		PARAMED ED	Subtotal	Intern &	Total	
STORPANN Adj SUSTINUTE		·		PRGM		Resi dents		
BAN SERVICE CRIST CHATES 22.00 25.00 24.00 25.00 26.00 26.00 27.00 2			APPRV			Cost & Post		
DEMPARE SERVICE OOST CENTERS 22.00 23.00 24.00 25.00 26.00								
SPAREMENT SCHWICHT CONST. CENTERS 1.00 DOTOID CAP SELL COSTS - MARKE & FIXTY			22.22	22.22	04.00		27.00	
1.00		OFNEDAL CEDIU OF OCCT OFNEDC	22. 00	23. 00	24.00	25. 00	26.00	
2.00	1 00		T				Ι	1 00
0.000 DIPPLOYEE BENEFITS CEPARTMENT								
0.000 0.000 AUMINI STRATION C. GENTRAL								1
7.00 00700 DOPERATION OF PELANT		1 1						5.00
0.00 0.0000 LAURDAY & LI NEN SERVICE		1 1						7. 00
10.00 1000 IN FTARY								8.00
12.00 01200 MAINTENANCE OF PERSONNE! 12.00 13.00 1	9.00	00900 HOUSEKEEPI NG						9.00
13.00 01300 MIRSH NG ADMINI STRATION 14.00 01400 01500 PHARMACY 15.00 01500 01185 GRINBAR SERVICES 16.00 01500 01850								10.00
14.00 01400 CENTRAL SERVICES & SUPPLY								12.00
15.00 01500 PHARMACY 15.00 17.00								13.00
16.00 1600 IEDICAL, RECORDS & LIERARY 16.00 17.00 1700 1								1
17.00 1700 SOCIAL SERVICE		1 1						•
18. DO 01800 OTHER CEMERAL SERVICES 18. DO 02000 MUNREYNIC CAN MISSTHETISTS 20. 00 2000 MUNREYNIC CAN MISSTHETISTS 20. 00 20.								
19.00 01900 NORPHYSIC IAM AMESTHETI STS 20.00 20200 20200 18R SERVICES-SALARY & FRINGES APPRY 0 21.00 20200 18R SERVICES-SALARY & FRINGES APPRY 0 21.00 20200 18R SERVICES-SALARY & FRINGES APPRY 0 22.00 20200 18R SERVICES-SALARY & FRINGES APPRY 0 22.00 20200		l l						1
20.00								19.00
21.00		1 1						20.00
22.00 02200 PARAMEDE DE PROM 0 22.00 23.00								21.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS	22.00		0					22.00
30. 00 030000 ADULTS & PEDIATRICS 0 0 8, 369, 902 0 8, 369, 902 0 31, 00 310 0 0 0 0 0 0 0 0 0	23.00	02300 PARAMED ED PRGM		0				23.00
31.00 03100 INTERSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS						
31 01 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	8, 369, 902	0		1
32. 00 03200 03200 03200 0300			-	-		1		1
33.0 0 33300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 3.3 .0 40.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			-	
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34.00			0	0		0		1
40.00 04000 SUBPROVI DER - I PF			0	0				
11-00 04100 SUBPROVIDER - I IFF			0	0			-	
43.00 04300 NURSERY			0	0			-	
44.00 04400 SKILLED NURSING FACILITY		1 1	0	Ö		o o	-	
46.00 04600 OTHER LONG TERM CARE	44.00		0	0) c	0		
ANCI LLARY SERVICE COST CENTERS 50.00 50	45.00		0	0) (0	0	45.00
50.00 05000 05000 05000 0 0 33,782,756 0 33,782,756 0 0 0 0 0 0 0 0 0	46.00		0	0) (0	0	46. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0								
52.00 05200 05200 05200 05200 05200 05200 0530		1	1		1 ' '			•
53.00 05300 ANESTHESI OLOGY 0 0 79, 355 0 79, 355 53, 0				0	6, 160, 017	0		
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 1,637,941 0 1,637,941 54.00 54.01 03630 ULTRA SOUND 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0				0	70 255	0		
54. 01 03630 ULTRA SOUND 0 0 4,118 0 4,118 54.0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 0 58. 00 05800 MRI 0 0 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 0 60. 01 06000 LABORATORY 0 0 0 0 0 60. 01 06001 BLODD LABORATORY 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 63. 00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07000 DRUGS CHARGED TO PATI ENTS 0 0 2, 030, 838 0 2, 030, 838 71.00 71. 00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 77. 00 07700 07700 ALLOGRAPHY 0 0 0 0 0 78. 00 07800 CART T-CELL I IMMUNOTHERAPY 0 0 0 0 0 77. 00 07700 07			_	0				1
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		1 1		0			.,,	
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 55. 00				Ö				1
57.00 05700 CT SCAN 0 0 0 0 0 0 57.00			0	0		0		1
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0	57.00		0	0) c	0	0	1
60. 00 06000 LABORATORY 0 0 0 662, 256 0 0 662, 256 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00	05800 MRI	0	0) (0	0	58.00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 60. 0 61. 0 61. 0 61. 0 62. 0 62. 0 62.0 0 62.0 0 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 0 62. 0 63. 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0 63. 0 64. 0 0 6400 l NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 64. 0 65. 0 65. 0 65.0 0 6500 RESPI RATORY THERAPY 0 0 0 0 39, 190 0 39, 190 0 39, 190 65. 0 66. 0 0 6600 PHYSI CAL THERAPY 0 0 0 10, 362, 520 0 10, 362, 520 0 10, 362, 520 0 67. 0 68. 0 0 66800 SPECH PATHOLOGY 0 0 0 0 0 0 0 68. 0 669.00 LECTROCARDI OLOGY 0 0 0 0 0 0 0 68. 0 68. 0 66900 ELECTROCARDI OLOGY 0 0 0 42, 222 0 42, 222 0 69. 0 71. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 00		0	0) c	0	0	59.00
61. 00		1 1	0	0	662, 256	0		1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 39, 190 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 2, 030, 838 0 2, 030, 838 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 32, 132, 216 0 32, 132, 216 72. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 10. 42. 00 0 0 0 0 0 0 10. 40. 00 0 0 0 0 10. 40. 00 0 0 0 0 10. 40. 00 0 0 0 10. 40. 00 0 0 0 10. 40. 00 0 0 10. 40. 00 0 0 10. 40. 00 0 0 10. 40. 00 0 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 0 10. 40. 00 10.			0	0		0		1
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63.00 64.00 10 17 RAVENOUS THERAPY 0 0 0 0 0 0 0 0 65.00 65.00 65500 RESPI RATORY THERAPY 0 0 0 39, 190 0 39, 190 0 39, 190 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 10, 362, 520 0 10, 362, 520 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 0 0 42, 222 0 42, 222 69.00 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_) .			1
64. 00		1 1	0	0		0	-	
65. 00 06500 RESPIRATORY THERAPY 0 0 39, 190 0 39, 190 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 10, 362, 520 0 10, 362, 520 66. 00 067. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0				0			•	
66. 00 06600 PHYSI CAL THERAPY 0 0 10, 362, 520 0 10, 362, 520 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		1 1		0	20 100		-	1
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 42, 222 0 42, 222 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		1 1		0	1			1
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 42, 222 0 42, 222 0 42, 222 0 69. 00 0 0 0 0 0 0 0 0 0				i n) .5,552,526	o		1
69. 00 06900 ELECTROCARDI OLOGY 0 0 42, 222 0 42, 222 69. 00 70. 0		1	0	0)	o o		1
70. 00			0	0	42, 222	2 0		1
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0) (0		1
73. 00			0	0				•
74. 00 07400 RENAL DI ALYSIS 0 0 82 0 82 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 75. 00 77. 00 07500 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 89. 00			0	0				
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 0 0 0 0 0 0 0 0 0			0	0				•
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 00 00 00 00 00 00 00		1 1	0	0	82	9		1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 0 0 78. 00 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1 .		0				•
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00		1 1	-	0	1	,		1
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 89.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70.00		<u> </u>		,1	, 0		1 70.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 0	88. 00		0	n) 0	n	88. 00
		1 1		_	1		_	•
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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0168 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 1:38 pm INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHE Subtotal Intern & Total R PRGM COSTS PRGM Residents APPRV Cost & Post Stepdown Adjustments 22. 00 23. 00 24.00 25. 00 26.00 91. 00 09100 EMERGENCY 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 0 0 000000000 0 95.00 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COSTS 0 98.00 0 09900 CMHC 0 0 99.00 99.00 0 99. 10 09910 CORF 0 0 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 97, 008, 418 97, 008, 418 118. 00 118.00 0 0 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 00000 0 5, 034, 157 5, 034, 157 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 193.00 5, 397, 666 194.00 07950 SPORTS MEDICINE 0 5, 397, 666 194. 00 0 0 194. 01 07951 SENI OR CIRCLE 0 0 194. 01 0 Cross Foot Adjustments 0 200.00 200.00 0 0 0 0 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 107, 440, 241 107, 440, 241 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

				') 12/31/2023	5/30/2024 1: 3	
			CAPI TAL REI	ATED COSTS		,	
	Overland Beautiful	B1	DI DO A FLYT	MANDLE FOLLID	6 1 1 1 1 1	EMPL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs				DEI /IICIMEIT	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	_					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		0	0	0	0	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	94. 790	176, 956	0 271, 746	0	
7. 00	00700 OPERATION OF PLANT	0	533, 201	995, 392	1, 528, 593	0	
8. 00	00800 LAUNDRY & LI NEN SERVI CE	0	0 0	773, 372	1, 320, 373	0	
9. 00	00900 HOUSEKEEPI NG	0	0	Ö	0	0	
10.00	01000 DI ETARY	0	0	0	0	0	10.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	134, 113	250, 365	384, 478	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17.00
	01850 OTHER GENERAL SERVICES	o o	0	Ö	Ö	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00		0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	326, 146	608, 857	935, 003	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	320, 140	000, 037	755, 005	0	31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	Ö	Ö	0	31.01
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45.00	04500 NURSING FACILITY	0	0	0	0	0	1
46. 00	04600 OTHER LONG TERM CARE	0	0		ő	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1, 076, 652		3, 086, 568	0	50.00
51.00	05100 RECOVERY ROOM	0	200, 533		574, 892	0	51.00
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	110, 972	207, 165	318, 137	0	
54. 00	03630 ULTRA SOUND	0	110, 7/2	207, 103	310, 137	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	Ö	Ö	0	55.00
56.00	05600 RADI 0I 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	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	0	0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U	U	0	U	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	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	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	659, 043	1, 230, 315	1, 889, 358	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		o		ol	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	o	o	0	73. 00
	07400 RENAL DI ALYSI S	0	0	0	o	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	O	٥	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		n	0	
90.00	09000 CLI NI C	Ö	0	0	ő	0	1
91.00	09100 EMERGENCY	0	0	O	o	0	1
				'			

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 15-0168

CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP Subtotal EMPLOYEE BENEFITS DEPARTMENT				T	o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
Cost Center Description			CAPI TAL REI	LATED COSTS		37 307 2024 1. 0) piii
Assigned New Capital Related Costs BENEFITS DEPARTMENT							
Performance	Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
P2. 00							
Q2.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART O						DEPARIMENT	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			1 00	2.00	2.4	4.00	
OTHER REIMBURSABLE COST CENTERS O	92 ON DOZON ORSERVATION REDS (NON-DISTINCT PART	U	1.00	2.00		4.00	92.00
94. 00		1		l.	0		72.00
95. 00		0	0	0	0	0	94.00
96. 00		0	0	0	O		
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 108. 00		0	0	0	0	0	
99. 00		0	0	0	0	0	97.00
99. 10	98.00 09850 OTHER REIMBURSABLE COSTS	0	0	0	0	0	98. 00
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM	99. 00 09900 CMHC	0	0	0	0	0	99. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 108. 00	99. 10 09910 CORF	0	0	0	0	0	99. 10
102. 00	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 108.		0	0	0	0		
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 108. 00		0	0	0	0	0	102. 00
106. 00 10600 HEART ACQUISITION							
107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 108. 00 108. 00 108. 00 0 0 0 0 0 0 0 108. 00		0	0	1	_		
108.00 LUNG ACQUISITION 0 0 0 0 108.00		0	0	0	0		
		0	0	0	0		
		0	0	0	0		
	109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0 1110. 00 1111. 00 1111. 00 1110 I SLET ACQUI SI TI ON 0 0 0 0 0 0 0 0 1111. 00		0	0	0	0		
111. 00 11100 15LE1 ACQUISITION		U	U	0	U	0	
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00							
114. 00 1140 011 E12ATTON REVIEW-3NP 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 115. 00			0		0	0	
116. 00 11600 HOSPI CE			0		0		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 3, 135, 450 5, 853, 325 8, 988, 775 0 118.00			3 135 450	5 853 325	8 988 775		
NONREI MBURSABLE COST CENTERS		<u> </u>	3, 133, 430	3,000,020	0, 700, 773		1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00		0	0	0	0	0	190.00
191.00 19100 RESEARCH 0 0 0 0 191.00		0	0				
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 945, 999 1, 766, 012 2, 712, 011 0 192. 00		0	945, 999	1, 766, 012	2, 712, 011		
193. 00 1930 NONPAI D WORKERS 0 0 0 0 0 193. 00	193. 00 19300 NONPALD WORKERS	o	0	0	0	0	193.00
194. 00 0 7950 SPORTS MEDI CI NE 0 0 0 0 194. 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	194. 01 07951 SENI OR CIRCLE	0	0	0	o	0	194. 01
200.00 Cross Foot Adjustments 0 200.00	200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers 0 0 0 0 201.00	201.00 Negative Cost Centers		0	0	0		
202.00 TOTAL (sum lines 118 through 201) 0 4,081,449 7,619,337 11,700,786 0 202.00	202.00 TOTAL (sum lines 118 through 201)	0	4, 081, 449	7, 619, 337	11, 700, 786	0	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm

						5/30/2024 1:3	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	0.00	7. 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	271, 746	4 540 704				5.00
7. 00	00700 OPERATION OF PLANT	14, 141	1, 542, 734	0.45			7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	845 1, 875	0	845 0	1, 875		8. 00 9. 00
10. 00	01000 DI ETARY	537	0	0	1, 8/3	537	10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0		0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 841	0	Ö	o	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 674	59, 911	Ö	73	0	14.00
15.00	01500 PHARMACY	1, 180	0	0	o	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 700	0	0	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	1, 313	0	0	0	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
21. 00 22. 00	02200 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	J		<u>۱</u>		25.00
30.00	03000 ADULTS & PEDIATRICS	16, 435	145, 697	502	177	537	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	О	0	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	O	0	31.01
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 I NTENSI VE CARE UNI T	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 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE		0	0		0	46.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		10.00
50.00	05000 OPERATI NG ROOM	75, 596	480, 963	343	584	0	50.00
51.00	05100 RECOVERY ROOM	13, 788	89, 582	0	109	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	120	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 557	49, 574	0	60	0	54.00
54. 01	03630 ULTRA SOUND	10	0	0	0	0	54.01
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	0	0	0	0	0	56. 00 57. 00
58. 00	05800 MRI	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		0	59.00
60.00	06000 LABORATORY	1, 619	0	Ö	o o	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	Ö	Ö	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						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	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	97	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	22, 982	294, 409	0	358	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	101	0	0	0	0	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 701	0	0	0	0	70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	75, 664	0	0		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 006	0	Ö	o	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	O	o	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	o	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY		0		0	0	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	"	U		۱	U	91.00
12.00	OTHER REIMBURSABLE COST CENTERS						, ,2.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	O	0	94.00
	09500 AMBULANCE SERVICES	l o	0			0	
		, ,		•			

| Period: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

			T	o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	O pili
0031 001101 203011 211 011	E & GENERAL	PLANT	LINEN SERVICE	HOUSEREEFTING	DI LIMIN	
	5. 00	7. 00	8. 00	9. 00	10.00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		o o	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	0	100.00
101.00 10100 HOME HEALTH AGENCY	0		0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	(0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0		0 0	0		105.00
106.00 10600 HEART ACQUISITION	0		0 0	0		106. 00
107.00 10700 LIVER ACQUISITION	0		0	0		107.00
108.00 10800 LUNG ACQUISITION	0		0	0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0		0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	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 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)	249, 782	1, 120, 13	845	1, 361	537	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0	0		190. 00
191. 00 19100 RESEARCH	0	(0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 344	422, 598	3 0	514		192. 00
193. 00 19300 NONPALD WORKERS	0	(0	0		193. 00
194. 00 07950 SPORTS MEDICINE	13, 620	(0	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	1 540 70	٥ ا	0		201.00
202.00 TOTAL (sum lines 118 through 201)	271, 746	1, 542, 73	4 845	1, 875	537	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm

				12/31/2023	5/30/2024 1: 3	
Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	OF PERSONNEL	ADMINISTRATIO N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	12. 00	13. 00	14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	T					1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI 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 01000 DI ETARY						10.00
12.00 01200 MAINTENANCE OF PERSONNEL	0					12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	2, 841	454 40/			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	451, 136	1 100		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	1, 180	2, 700	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE		0		0	2, 700	17. 00
18. 00 01850 OTHER GENERAL SERVICES	0	0	0	0	0	18. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	o o	Ö	0	Ö	19. 00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00 02300 PARAMED ED PRGM	0	0	0	0	0	23.00
I NPATIENT ROUTINE SERVICE COST CENTERS	1		0.470		0.1	
30. 00 03000 ADULTS & PEDI ATRI CS	0	774	3, 470	0	31	30.00
31. 00 03100 INTENSI VE CARE UNIT 31. 01 02060 NEONATAL INTENSI VE CARE UNIT	0	0	0	0	0	31. 00 31. 01
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 03300 BURN INTENSI VE CARE UNI T	0	0	0	0	0	33. 00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	Ō	Ö	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	O	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	44.00
45. 00 04500 NURSI NG FACILITY	0	0	0	0	0	45.00
46. 00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	1, 357	146, 220	0	639	50. 00
51. 00 05100 RECOVERY ROOM	0		140, 220	0	126	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	383	0	60	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1	0	0	57	54.00
54.01 03630 ULTRA SOUND	0	0	0	0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 01 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 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0	1, 084	0	0 28	59. 00 60. 00
60. 01 06000 LABORATORY	0))	1,004	0	0	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				J	O O	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	o	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	О	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	0	1	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1, 646	0	116	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0 5	68. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGY	0	0		0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16, 213	0	140	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	280, 221	0	1, 395	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	1, 180	102	73. 00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	-					00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0	0	89. 00 90. 00
91. 00 09100 EMERGENCY				0	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				O		92.00
OTHER REIMBURSABLE COST CENTERS						50
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
			<u>'</u>	'		

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

				То	12/31/2023	Date/Time Pre 5/30/2024 1:3	
	Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	D Dill
	oost contor boost per on		ADMI NI STRATI O	SERVICES &		RECORDS &	
		0. 12.10011122	N	SUPPLY		LI BRARY	
		12. 00	13. 00	14. 00	15. 00	16. 00	
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	O	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0	97.00
98.00 09850	OTHER REIMBURSABLE COSTS	0	0	0	0	0	98.00
99.00 09900	CMHC	0	0	0	0	0	99.00
99. 10 09910	CORF	0	0	0	0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECI A	AL 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	2, 841	449, 237	1, 180	2, 700	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100		0	0	0	0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	0	1	0		192.00
	NONPALD WORKERS	0	0	0	0		193.00
	SPORTS MEDICINE	0	0	1, 898	0		194.00
	SENIOR CIRCLE	0	0	0	0		194. 01
	Cross Foot Adjustments						200. 00
	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	2, 841	451, 136	1, 180	2, 700	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0168

					12/31/2023	5/30/2024 1: 3	
			OTHER GENERAL			INTERNS &	
	Cost Center Description	SOCI AL	SERVI CE S	NONPHYSI CI AN	NURSI NG	RESI DENTS SERVI CES-SALA	
	Cost Center Description	SERVI CE	3	ANESTHETI STS	PROGRAM	RY & FRINGES	
		02 02		72011.211010		APPRV	
	1	17. 00	18. 00	19. 00	20.00	21. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT		I			T	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 9. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00							14. 00
15.00	01500 PHARMACY						15.00
16. 00 17. 00		1, 313					16. 00 17. 00
18. 00		0	0				18.00
19. 00		0	Ō				19.00
20.00	02000 NURSI NG PROGRAM	0	0		C		20.00
21. 00		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 INPATIENT ROUTINE SERVICE COST CENTERS	0	0				23.00
30. 00		1, 313	0				30.00
31.00	1	0					31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0	0	•			31. 01
32.00	· ·	0	0				32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0				33. 00 34. 00
40.00	1	0	0				40.00
41. 00	1	Ö	Ö				41.00
43.00	l l	0	0				43.00
44.00	04400 SKILLED NURSING FACILITY	0	0				44.00
45. 00 46. 00	1	0	0				45. 00 46. 00
46.00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0					46.00
50.00	05000 OPERATI NG ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 54. 00		0	0				53. 00 54. 00
54. 00	03630 ULTRA SOUND	0					54.00
55. 00		0	Ö				55.00
56.00	05600 RADI 0I SOTOPE	0	0				56.00
	05700 CT SCAN	0	0				57.00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0				58.00
59. 00 60. 00	06000 LABORATORY	0					59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	Ö	Ö				60.01
61.00	1						61.00
62.00	· ·	0	0				62.00
63.00	1	0	0				63.00
64. 00 65. 00	· ·	0	0				64. 00 65. 00
66. 00	· ·	0					66.00
67. 00	· ·	0	Ö				67.00
68. 00		0	0				68. 00
69.00		0	0				69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00		Ö	0				73.00
	07400 RENAL DIALYSIS	0	0				74.00
75. 00		0	0				75.00
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0				77. 00 78. 00
10. UU	OUTPATIENT SERVICE COST CENTERS	0					, 70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	09000 CLINIC	0	0				90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				91.00 92.00
7Z. UU	OVERAL DEPT. (NOW-DISTINCT PART	l	<u>I</u>	I .		1	72.00

			T ₁	rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	narod:
			''	0 12/31/2023	5/30/2024 1: 3	
		OTHER GENERAL			INTERNS &	<u> </u>
		SERVI CE			RESI DENTS	
Cost Center Description	SOCI AL	S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	
· ·	SERVI CE		ANESTHETI STS	PROGRAM	RY & FRINGES	
					APPRV	
	17. 00	18. 00	19.00	20.00	21.00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	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
99. 00 09900 CMHC	0	Ó				99.00
99. 10 09910 CORF	0	0				99. 10
100.00 10000 L&R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	Ö				101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	Ö				102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUISITION	0	0				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 I NTESTI NAL ACQUI SI TI ON	0	0				110.00
111. 00 11100 SLET ACQUISITION	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	_	_				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 313	0		0	0	118.00
NONREI MBURSABLE COST CENTERS	., 0.0					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
191. 00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CI ANS' 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 CIRCLE	l 0	0				194. 01
200.00 Cross Foot Adjustments		١	0	0	n	200.00
201.00 Negative Cost Centers	n	0	_	0		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 313			-		202.00
202. 00 TOTAL (Suil TITIOS TTO THE OUGH 201)	1, 515	٥	1	0	1	1202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co	F	Period: From 01/01/2023	Worksheet B Part II	
				1	To 12/31/2023	Date/Time Pre 5/30/2024 1:3	pared: 8 pm
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	OFNEDAL CEDILLOS COCT CENTEDO	22. 00	23. 00	24. 00	25.00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 PARAMED ED PRGM	0	0				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 20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 31. 01 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 02060 NEONATAL 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			1, 103, 939		1, 103, 939 0 0 0 0 0 0 0 0 0	30.00 31.00 31.01 32.00 33.00 34.00 40.00 41.00 43.00 45.00 46.00
	ANCILLARY SERVICE COST CENTERS						
74.00	05000 OPERATING ROOM 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 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL. DEV. CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07700 ALDGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL IMMUNOTHERAPY			3, 792, 270 679, 203 (5563 371, 388 ((((((((((((((((((3, 792, 270 679, 203 0 5673 371, 386 10 0 0 0 0 0 2, 734 0 0 98 2, 208, 869 0 0 106 21, 054 357, 280 4, 288 0 0 0 0	51.00 52.00 53.00 54.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER			(0	88. 00 89. 00
	09000 CLI NI C				1	0	

Health Financial Systems	UTHERAN MUSCULOS	SKELETAL CENTE	R	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0168	Peri od: From 01/01/2023 Part II To 12/31/2023 Date/Ti me 5/30/2024		epared: 38 pm
Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHE R PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	22. 00	23. 00	24. 00	25. 00	26.00	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 (91.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S				0		94.00
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD				0 0		96.00
98.00 09850 OTHER REIMBURSABLE COSTS						1
99. 00 09900 CMHC				0	1	99.00
99. 10 09910 CORF				0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				0 (100.00
101.00 10100 HOME HEALTH AGENCY				0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM				0 (102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON				0		105.00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION						106.00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION						108.00
109. 00 10900 PANCREAS ACQUISITION						109.00
110. 00 11000 NTESTINAL ACQUISITION				0		110.00
111. 00 11100 SLET ACQUISITION				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		115. 00
116. 00 11600 HOSPI CE				0 (116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	8, 541, 8	00 (8, 541, 800	118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 (190.00
191.00 19100 RESEARCH					1	191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES			3, 143, 4		3, 143, 468	
193. 00 19300 NONPALD WORKERS			3, 110, 1	0		193.00
194. 00 07950 SPORTS MEDICINE			15, 5	18	15, 518	194.00
194. 01 07951 SENI OR CIRCLE				0	1	194. 01
200.00 Cross Foot Adjustments	0	0		0	1	200.00
201.00 Negative Cost Centers	0	0	1	0 (201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	11, 700, 7	86 (11, 700, 786	202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0168 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFLTS** F & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARIES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 214.643 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 214, 643 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 27, 260, 361 4.00 4.00 4, 985 5, 700, 586 88, 796, 229 00500 ADMINISTRATIVE & GENERAL 4, 985 5.00 -18, 644, 012 5.00 7.00 00700 OPERATION OF PLANT 28, 041 28, 041 103, 555 4, 621, 319 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 276, 206 8.00 00900 HOUSEKEEPI NG 612, 602 9 00 0 C 1 083 0 9 00 10.00 01000 DI ETARY 0 C 151 0 175, 388 10.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 01300 NURSING ADMINISTRATION 0 703, 627 0 0 928, 279 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 7,053 7.053 580 851 2, 181, 082 14 00 14 00 15.00 01500 PHARMACY 280, 883 385, 745 15.00 01600 MEDICAL RECORDS & LIBRARY 0 55, 423 0 882, 365 16.00 16.00 0 01700 SOCIAL SERVICE 0 328, 394 428, 934 17.00 0 17.00 0 0 01850 OTHER GENERAL SERVICES 18 00 C 0 0 18 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 0 0 20.00 02000 NURSING PROGRAM 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21 00 C 0 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 0 0 22.00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 152 17, 152 2, 689, 510 5, 371, 018 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 0 0 31.01 0 0 31.01 03200 CORONARY CARE UNIT 0 0 32.00 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 C 0 33.00 o 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 0 0 40 00 0 40.00 0 04100 SUBPROVI DER - I RF 0 0 41.00 0 0 41.00 04300 NURSERY 0 43 00 C 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 44.00 0 0 45 00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 56, 621 56, 62 7. 183. 990 24, 704, 567 50.00 51.00 05100 RECOVERY ROOM 2, 174, 815 0 4, 505, 956 51.00 10.546 10, 546 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 \cap Ω 52.00 53.00 05300 ANESTHESI OLOGY 0 0 39, 314 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,836 5,836 476,003 0 1, 162, 468 54.00 o 3, 390 03630 ULTRA SOUND 54.01 54.01 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 C 0 Ω 55.00 56, 00 05600 RADI OI SOTOPE 0 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 0 05800 MRI 0 58 00 0 0 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 06000 LABORATORY 0 0 60.00 35, 909 529,093 60.00 0 0 06001 BLOOD LABORATORY 60.01 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 0 O 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 0 64 00 06400 INTRAVENOUS THERAPY 0 0 64 00 06500 RESPIRATORY THERAPY 0 65.00 0 52 31,860 65.00 06600 PHYSI CAL THERAPY 34, 659 3, 841, 232 0 7, 510, 437 66.00 34, 659 66.00 0 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 67.00 0 06800 SPEECH PATHOLOGY 0 68 00 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0 C 902 32, 921 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 70.00 0 0 1, 536, 428 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 24, 716, 545 72 00 72.00 0 o 73.00 07300 DRUGS CHARGED TO PATIENTS 0 982, 472 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 77 00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90. 00 09000 CLINIC 0 0 ol 90.00 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 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm CAPITAL RELATED COSTS Reconciliatio ADMINISTRATIV Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 91. 00 09100 EMERGENCY 91.00 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 09850 OTHER REIMBURSABLE COSTS 0 0 98 00 0 09900 CMHC 0 99.00 C 0 99. 10 09910 CORF 0 0 0 O 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 Ω 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 106.00 10600 HEART ACQUISITION 0 0 0 Ω 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 C 0 111.00 11100 I SLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 164, 893 164, 893 24, 156, 966 -18, 644, 012 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191. 00 19100 RESEARCH 0 0 0

Heal th	Financial Systems	LUTHERAN MUSCULO	SKELETAL CENTER	?	In Lie	u of Form CMS-2	2552-10
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CO	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/30/2024 1:3	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	piii
	OFNEDAL CERVILOE COCT OFNEDO	7. 00	8. 00	9. 00	10.00	12. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	181, 617 0 0 0 0 0 7, 053 0 0 0	47, 997 0 0 0 0 0 0 0	181, 617 0 0 7, 053 0 0 0 0	15, 402 0 0 0 0	0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL 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 04500 OTHER LONG TERM CARE	17, 152 0 0 0 0 0 0 0 0 0		17, 152 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	56 621	19 469	56, 621	0	0	50 00
51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 59. 00 60. 01 61. 00 62. 00 64. 00 65. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 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 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 077001 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I IMMUNOTHERAPY	56, 621 10, 546 0 5, 836 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10, 546 0 0 5, 836 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 67. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00 78. 00
89. 00 90. 00 91. 00	O8800 RURAL HEALTH CLINIC O8900 FEDERALLY QUALIFIED HEALTH CENTER O9000 CLINIC O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	000000000000000000000000000000000000000	0 0		0 0	0 0 0 0	89. 00 90. 00

Heal th Finar	ncial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	₹	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre	pared:
	Cook Cooker Doorwinking	ODEDATION OF	I ALINDDY 0	HOUSEKEEDING	DIETARY	5/30/2024 1: 3	8 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		MAI NTENANCE	
		PLANT	LI NEN SERVI CE	(SQUARE FEET)		OF PERSONNEL	
		(SQUARE FEET)	(POUNDS OF		SERVED)	(NUMBER	
			LAUNDRY)			HOUSED)	
		7. 00	8. 00	9. 00	10.00	12. 00	
	REI MBURSABLE COST CENTERS						
	HOME PROGRAM DIALYSIS	0	0		0		
95.00 09500	AMBULANCE SERVICES	0	0		0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98. 00 09850	OTHER REIMBURSABLE COSTS	0	0		0	0	98.00
99.00 09900		0	0		0 0	0	
99. 10 09910		0	0		0 0	o o	
	I&R SERVICES-NOT APPRVD PRGM	0	0		0	1	100.00
	HOME HEALTH AGENCY	0	0		0 0		100.00
		0	0		-		
	OPIOID TREATMENT PROGRAM	0	0		0 0	0	102.00
	AL PURPOSE COST CENTERS	_	_	ı	_1	_	
	KIDNEY ACQUISITION	0	0		0		105.00
	HEART ACQUISITION	0	0		0		106. 00
	LIVER ACQUISITION	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
	ISLET ACQUISITION	0	0		0		111.00
	INTEREST EXPENSE		Ü		ŭ .	Ŭ	113.00
	UTILIZATION REVIEW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	_	115.00
		0	0		0		
116.00 11600		101 017	47.007	404.07	0	l	116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	131, 867	47, 997	131, 86	7 15, 402	0	118.00
	I MBURSABLE COST CENTERS	_	_			_	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	l	190.00
191. 00 19100		0	0		0		191. 00
	PHYSICIANS' PRIVATE OFFICES	49, 750	0	49, 75	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	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,	5, 591, 630	334, 199	741, 22	6 212, 213	_	202.00
202.00	Part I)	5, 571, 030	334, 177	/41,22	0 212, 213	٥	202.00
202.00		20 700022	4 04 201 4	4 00105	0 12 770274	0 000000	202 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	30. 788032	6. 962914			l	
204.00	Cost to be allocated (per Wkst. B,	1, 542, 734	845	1, 87	5 537	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	8. 494436	0. 017605	0. 01032	4 0. 034866	0. 000000	205.00
22/ 5-	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						L
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	1		l		l	l

	•	LUTHERAN MUSCULUS				u or form CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provi der CC	JN: 15-0168	Peri od: From 01/01/2023	Worksheet B-1	
					To 12/31/2023	Date/Time Pre	
	Cost Contan Decement on	MIDCING	CENTRAL	DHADMACV	MEDICAL	5/30/2024 1: 3	8 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	SOCI AL SERVI CE	
		N N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED	REGOT 5.)	(GROSS CHAR	(TTIME OF EIVE	
		NRSI NG HRS)	REQUIS.)		GES)		
		13. 00	14. 00	15. 00	16.00	17. 00	
4 00	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 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 NURSI NG ADMI NI STRATI ON	8, 054, 299					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	38, 975, 084	007.00			14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	987, 93	0 1, 100, 624, 704		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		0		0 1, 100, 624, 704	3, 734	1
18. 00	01850 OTHER GENERAL SERVICES		0		0 0	0,734	18.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0		0 0	Ö	19.00
20. 00	02000 NURSI NG PROGRAM	o	o		0 0	Ō	20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	o	О		0 0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	o	O		0 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 & PEDIATRICS	2, 193, 044	299, 821		0 15, 696, 196		
31.00	03100 NTENSIVE CARE UNIT	0	0		0 0	0	31.00
31. 01 32. 00	02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0		0		31.01
33. 00	03300 BURN INTENSIVE CARE UNIT		0		0 0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		o		0 0	Ö	34.00
40. 00	04000 SUBPROVI DER - I PF	o	o		0 0	Ö	40.00
41.00	04100 SUBPROVI DER - I RF	o	0		0 0	0	41.00
43.00	04300 NURSERY	o	0		0 0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45. 00	04500 NURSING FACILITY	0	0		0 0	0	45.00
46. 00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 847, 008	12, 632, 436		0 319, 262, 825	0	50.00
51.00	05100 RECOVERY ROOM	2, 001, 283	12, 032, 430		0 63, 050, 833		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2,001,200	o		0 00,000,000	Ö	52.00
53.00	05300 ANESTHESI OLOGY	o	33, 104		0 30, 243, 642	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 152	0		0 28, 453, 753	0	54.00
54. 01	03630 ULTRA SOUND	0	0		0 16, 435		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	1	1
	05600 RADI OI SOTOPE	0	0		0	0	
57. 00 58. 00	05700 CT SCAN	0	0		0	0	
59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	58. 00 59. 00
60.00	06000 LABORATORY	9, 910	93, 620		0 14, 186, 935		60.00
60. 01	06001 BLOOD LABORATORY	7, 710	73, 020		0 14, 100, 739	0	60.01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	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	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0		0 661, 225	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	142, 229		0 57, 835, 216	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	902	0		0 2, 333, 281	0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI	902	0		0 2, 333, 261		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	1, 400, 714		0 70, 240, 626	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	24, 209, 059		0 447, 516, 869	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	987, 93		Ö	73.00
74.00	07400 RENAL DIALYSIS	0	o		0 84, 257	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	o		0	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78. 00	07800 CAR T-CELL I MMUNOTHERAPY	0	0		0 0	0	78.00
00.00	OUTPATIENT SERVICE COST CENTERS		اء		0 ^	_	00.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0				89. 00 90. 00
91.00	09100 EMERGENCY		٥		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ				92.00
	•		'		*		·

Health Financial Systems	LUTHERAN MUSCULOS	KELETAL CENTER	In Li	eu of Form CMS-2552-10
COCT ALLOCATION CTATIC	TICAL DACIC	D	Davet and	Wasalialaaa D 1

Health Financial Systems LU	THERAN MUSCULOS	KELETAL CENTER	R	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2023		
				To 12/31/2023		
0 1 0 1 0 1 1	NUIDOL NIO	OFNITRAL	BUARA OV	HED! OA!	5/30/2024 1: 3	8 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
	N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DI RECT	(COSTED		(GROSS CHAR		
	NRSI NG HRS)	REQUIS.)		GES)		
	13. 00	14. 00	15. 00	16. 00	17. 00	
OTHER REIMBURSABLE COST CENTERS	,		,	_	,	
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0		
95. 00 09500 AMBULANCE SERVICES	0	0		0	1	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	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	99.00
99. 10 09910 CORF	0	0	1	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	o	0		o o	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	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	o o	0		0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0		0		110.00
111.00 11100 SLET ACQUISITION		0		0	0	
113. 00 11300 NTEREST EXPENSE		O	Ì		l	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		0	١	115.00
116. 00 11600 HOSPI CE		0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 054, 299	38, 810, 983	007 02	2 1, 100, 624, 704		118.00
NONREI MBURSABLE COST CENTERS	0,034,277	30, 010, 703	707, 73	2 1, 100, 024, 704	3, 734	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	d .	0 0	1	190. 00
191. 00 19100 RESEARCH		0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		109		0		192.00
193. 00 19300 NONPALD WORKERS		107		0		193.00
194. 00 07950 SPORTS MEDICINE		163, 992		0		194.00
194. 01 07951 SENI OR CI RCLE		103, 992		0		194. 00
200.00 Cross Foot Adjustments	١	U		0	0	200.00
						200.00
	1 100 104	2 004 074	4// 70	1 0/7 /20	F10 00F	
202.00 Cost to be allocated (per Wkst. B,	1, 123, 184	2, 884, 964	466, 73	8 1, 067, 630	518, 995	202.00
Part I)	0 100451	0.074001	0 47040	0 000070	120 001/00	202 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 139451	0. 074021	1			1
204.00 Cost to be allocated (per Wkst. B,	2, 841	451, 136	1, 18	0 2, 700	1, 313	204. 00
Part II)	0.000050	0.044575	0 00110	4 000000	0.054/04	005 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000353	0. 011575	0. 00119	4 0. 000002	0. 351634	205.00
NAUE adjustment amount to be all sected						201 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	1		I	1	I	I

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

					0 12/31/2023	Date/lime Pre 5/30/2024 1:3	
		OTHER GENERAL			INTERNS &	RESI DENTS	
	Cost Center Description	SERVI CE S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	
	·	(TIME SPENT)	ANESTHETI STS	PROGRAM	RY & FRINGES	R PRGM COSTS	
			(ASSI GNED TIME)	(ASSIGNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	
			TTWIL)	11 ML)	TIME)	TIME)	
	OFNEDAL CEDIL OF COCT OFNEDO	18. 00	19. 00	20. 00	21.00	22. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE						8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
10. 00 12. 00	01200 MAINTENANCE OF PERSONNEL						10. 00 12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00 19. 00	O1850 OTHER GENERAL SERVICES O1900 NONPHYSICIAN ANESTHETISTS	0	0				18. 00 19. 00
20.00	02000 NURSI NG PROGRAM	0		c			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0		21. 00
22. 00 23. 00	O2200 I &R SERVICES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM	0				0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0					23.00
30.00	03000 ADULTS & PEDIATRICS	0	0				30.00
31. 00 31. 01	03100 INTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	0	0	C		•	31. 00 31. 01
32. 00	03200 CORONARY CARE UNIT	0	0	Č	-	1	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	C	-	1	33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	C	-	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	Č	Ö	Ö	41. 00
43.00	04300 NURSERY	0	0	C	-	1	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	C	-	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0				46. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM		0		0	0	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	0	0			-	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	53. 00 54. 00
54. 00	03630 ULTRA SOUND	0	0		0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	C			55. 00
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	C			56. 00 57. 00
58. 00	05800 MRI	0	0			0	58.00
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	C	0	0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					Ĭ	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	1	62.00
64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0) 0		0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	Ö	Č	Ö	ő	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	Ö	Č	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	o o	o o	73. 00
	07400 RENAL DIALYSIS	0	0	C	0	0	74.00
75. 00 77. 00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC HSCT ACQUISITION		0		0	0	75. 00 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0			_	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0	0	00 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				88. 00 89. 00
	09000 CLI NI C	0	0		-	-	90.00
	<u> </u>	<u>-</u>		<u> </u>			

				Ţ	o 12/31/2023		
		OTHER GENERAL			INTEDNC 0	5/30/2024 1: 3 RESI DENTS	s pm
		SERVI CE			INTERNS &	KESIDENIS	
	Cost Center Description	S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	SERVI CES_OTHE	
	oost center bescription	(TIME SPENT)	ANESTHETI STS	PROGRAM	RY & FRINGES	R PRGM COSTS	
		(TTWE STEINT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
			111112)	11	TIME)	TIME)	
		18. 00	19. 00	20.00	21. 00	22. 00	
91.00 09100	EMERGENCY	0					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER	REIMBURSABLE COST CENTERS						
94.00 09400	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	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
102.00 10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0	0			105.00
	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			116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100		0	0	0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	NONPALD WORKERS	0	0	0	0		193.00
	SPORTS MEDICINE	0	0	0	0		194.00
	SENI OR CIRCLE	0	0	0	0		194. 01
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	0	202. 00
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,	n 0.00000	0.000000	0.00000	0.00000		204. 00
_0 00	Part II)		l			l	_ 5 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
206. 00	II) NAHE adjustment amount to be allocated			0			206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,			0. 000000			207. 00
207.00	Parts III and IV)			0.00000			201.00

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

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10 00 01200 MAINTENANCE OF PERSONNEL 12.00 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 17.00 01700 SOCIAL SERVICE 17.00 18.00 01850 OTHER GENERAL SERVICES 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING PROGRAM 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 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 31.00 31 01 02060 NEONATAL INTENSIVE CARE UNIT 31 01 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 0 43.00 44 00 04400 SKILLED NURSING FACILITY 44 00 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50 00 0 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 000000000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 54 00 54.01 03630 ULTRA SOUND 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 05600 RADI OI SOTOPE 56.00 56, 00 57.00 05700 CT SCAN 57.00 58.00 05800 MRI 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 06000 LABORATORY 60.00 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. 0000000000000 63.00 63.00 64.00 06400 INTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66,00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 74 00 74 00 75. 00 | 07500 | ASC (NON-DISTINCT PART) 75.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90. 00 09000 CLINIC 90 00 09100 EMERGENCY 91.00 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00

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

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 95. 00 09500 AMBULANCE SERVICES 95 00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 00000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 98.00 09850 OTHER REIMBURSABLE COSTS 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 101.00 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 106.00 106.00 10600 HEART ACQUISITION 00000 107.00 10700 LIVER ACQUISITION 107. 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 ACQUISITION 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.) 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 0 118.00 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 193. 00 19300 NONPAI D WORKERS 193.00 194.00 07950 SPORTS MEDICINE 194.00 194. 01 07951 SENI OR CIRCLE 0 194. 01 200 00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 II) 206.00 206.00 NAHE adjustment amount to be allocated 0 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Health Financial Systems

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

				'	0 12/31/2023	5/30/2024 1: 3	
			Title	XVIII	Hospi tal	PPS	
	Cook Cooks Doors at a	T-+-! C+	Th	Tabal Casta	Costs	Tatal Casta	
	Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		B, Part I,	Auj .		Di Sai i Owance		
		col . 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.040.000	T	0.040.000		0.040.000	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 369, 902 0		8, 369, 902 0	0	8, 369, 902 0	30. 00 31. 00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	0			0		31.00
32. 00	03200 CORONARY CARE UNIT	0			0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0	Ö	ő	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0		0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	0		0	0	0	41.00
43. 00	04300 NURSERY	0		0	0	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	ANCILLARY SERVICE COST CENTERS	0			0	,, 0	40.00
50.00	05000 OPERATI NG ROOM	33, 782, 756		33, 782, 756	0	33, 782, 756	50.00
51.00	05100 RECOVERY ROOM	6, 160, 017		6, 160, 017	0	6, 160, 017	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	1	52.00
53. 00	05300 ANESTHESI OLOGY	79, 355		79, 355	0	1 ,	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 637, 941		1, 637, 941	0	1, 637, 941	54.00
54. 01 55. 00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	4, 118 0		4, 118	0	4, 118 0	54. 01 55. 00
56. 00	05600 RADI OI SOTOPE	0			0		56.00
57. 00	05700 CT SCAN	0		0	0	o o	57.00
58. 00	05800 MRI	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59.00
60.00	06000 LABORATORY	662, 256		662, 256	0	662, 256	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0		64.00
65. 00	06500 RESPIRATORY THERAPY	39, 190	0	39, 190	0	39, 190	65.00
66. 00	06600 PHYSI CAL THERAPY	10, 362, 520			Ö		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	42, 222		42, 222	0	42, 222	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0 000 000		0	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 030, 838 32, 132, 216	l .	2, 030, 838 32, 132, 216	0	2, 030, 838 32, 132, 216	
	07300 DRUGS CHARGED TO PATIENTS	1, 705, 005		1, 705, 005	0	1, 705, 005	73.00
74.00	07400 RENAL DIALYSIS	82	l .	82	Ö	82	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00		0		0	0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS			1 0	0	0	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	88. 00 89. 00
	09000 CLINIC	0		0	0	ő	90.00
	09100 EMERGENCY	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 851, 062		2, 851, 062		2, 851, 062	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0		0			94.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0	0	95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0		97.00
	09850 OTHER REIMBURSABLE COSTS	0		0	0	o o	98.00
	09900 CMHC	0		Ö	_	0	
99. 10	09910 CORF	0		0		0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0		0		•	100.00
	10100 HOME HEALTH AGENCY	0		0		•	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0		0		0	102. 00
105.00	SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON	0		T 0		0	105. 00
	10600 HEART ACQUISITION	0		0			106.00
	10700 LI VER ACQUI SI TI ON	0		0		•	107. 00
108.00	10800 LUNG ACQUISITION	0		0		•	108. 00
	10900 PANCREAS ACQUISITION	0		0			109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0		0		•	110.00
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE	0		0		•	111. 00 113. 00
113.00	I I J J J J I N I L N L L N J L N	l	<u> </u>	<u> </u>	<u> </u>	1	1113.00

Health Financial Systems	UTHERAN MUSCULO	SKELETAL CENTER	?	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 99, 859, 480 2, 851, 062 97, 008, 418		2, 851, 06	2		201. 00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Health Financial Systems

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

Charges						0 12/31/2023	5/30/2024 1: 3	
Cost Center Description					XVIII	Hospi tal	PPS	
INVESTMENT STATUTE SERVICE CORST CENTERS 8,00 7,00 8,00 9,00 10,00		Cost Center Description	I npati ent				I npati ent	
30.00 30.000 AURLIES & PERIATRICS B, 675, 321 B, 675, 321 30.00 30.00 31.00 31.00 30.00 31.00		T	6. 00	7. 00	8. 00	9. 00		
31.00 GOTOD INTERSIVE CASE UNIT 0 0 0 0 1 31.00 37.0	30.00		8 675 321		8 675 321			30.00
31.01 DOSCO MINDMAIN INTERINF CARE UNIT 0 33.00 33.00 330.00 33			0, 073, 321					
33.00 03300 BURN INTERSIVE CARE UNIT			0		0			
34.00 0.0400 SURREJORA INTENSIVE CARE UNIT 0		l l	0		0			1
40.00 0.0000 SUBPROVIDER - 1 FF			0		0			1
11.00 04300 SUBPROVIDER - 1 RF			0		0			
43.00 0/3300 NURSENT 0 0 0 44.00 44.00 0/350 NURSENT 67.01 17.			l o		Ö			1
45.00 04600 DIRRS IND. FACILITY	43.00		0		0			43.00
46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 46. 00 4			0		0			
MICHELERY SERVICE COST CENTERS			0		0			1
50.00 GEODG GERDATING ROOM 6.3, 30.6, 86.3 255, 955, 96.2 319, 262, 825 0. 105615 0. 0000000 51.00 52.00 0. 2000 DELIVERY ROOM & LABOR ROOM 0 0. 2000000 52.00 0. 20000000 52.00 0. 2000000 52.00 0. 2000000 52.00 0. 20000000 0. 20000000 0. 2000000 0. 2000000 0. 2000000 0. 2000000 0. 2	40.00		<u> </u>					40.00
52.00 05200 DELI LYERY RODM & LABOR ROOM 0 0 0 0 0 0 0 0 0	50.00	05000 OPERATING ROOM		255, 955, 962	319, 262, 825		0. 000000	50.00
53.00 05300 AMESTHESIOLOGY 8, 298, 827 21, 944, 815 30, 245, 642 0, 000000 54, 00 54			1					1
54.00 05400 RADI OLOGY-DI AGNOSTI C 3,298, 469 25,155, 264 28,453,753 0.057565 0.000000 54.01 0.3530 UITAR SUNDIN C 15,066 1.379 16,435 0.250563 0.000000 54.01 0.550.00 0.5500 RADI OLOGY-THERAPEUTI C 0 0 0 0.000000 0.000000 55.00 0.5500 0.5500 0.000000 0.000000 0.000000 55.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.50000 0.50000 0.50000 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000				-	-			
54.01 03630 ULTRA SOUND 15.056 1.379 16.435 0.25053 0.000000 55.00 55.00 05600 RADI OLSOT-HERAPEUTIC 0 0 0 0 0 0.000000 0.000000 55.00 55.00 05600 RADI OLSOT-HERAPEUTIC 0 0 0 0 0 0.000000 0.000000 55.00 55.00 05600 RADI OLSOT-HERAPEUTIC 0 0 0 0 0 0.000000 0.000000 57.00 57.00 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.000000 0.000000 57.00 0.0000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000			1					
56.00 05600 RADIO ISOTOPE 0 0 0 0 0 0 0 0 0	54. 01		1					
57.00 05700 CT SCAN 0 0 0 0 0 0 0.000000 0.000000 57.00			0	0	0			
58. 00 05800 MRI 0 0 0 0 0 0 0 0 0			0	0	0			
59.00 05900 CARDATAC CATHETER IZATION 0 0 0 0.000000			0	0	0			
60.00	59. 00		0	0	0			1
61.00 06100 PBP CLINICAL LAB SERVICES-PREM ONLY 0 0 0 0 0 0 0 0 0		1	6, 573, 504	7, 613, 431	14, 186, 935			
62.00 06-200 WHOLE BLOOD & PACKED RED BLOOD CELL 0			0	0	0			
63.00 06.300 06.000 STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0			0	0	0			
65.00 06500 RESPIRATORY THERAPY 3,670,399 20,8925 661,225 0.059269 0.000000 65.00			0	0	Ö			
66.00 06600 PHYSI CAL THERAPY 3,670,399 54,164,817 57,835,216 0.179173 0.000000 66.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.0			0	0	0			
67. 00 06700 06700 06700 06700 06700 06700 06700 068. 00 06800 06800 06800 06800 06800 06800 06800 06800 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 06900 070000 06900 070000 06900 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 070000000 070000000 0700000000			1					
68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0		l l	3, 670, 399					
70.00 07000 Carrier			O	0				
171 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 25, 233, 442 45, 007, 184 70, 240, 626 0, 028913 0, 000000 71, 00 72, 00 07200 IMPL. DEV. CHARGED TO PATIENTS 175, 833, 040 271, 683, 829 447, 516, 869 0, 071801 0, 000000 72, 00 73, 00 74, 00 07400 RENAL DIALYSIS 82, 176 2, 081 51, 042, 611 0, 033404 0, 000000 73, 00 74, 00 0, 000000 0, 000000 74, 00 0, 000000 74, 00 0, 000000 74, 00 0, 000000 74, 00 0, 000000 74, 00 0, 000000 74, 00 0, 000000 75, 00 75, 00 0, 000000 76, 00 0, 000000 76, 00 0, 000000 76, 00 0, 000000 76, 00 76, 00 76, 00 76, 00 76, 00 76, 00 76, 00 76, 00 77, 0			799, 473	1, 533, 808	2, 333, 281			
172.00 07200 IMPL DEV. CHARGED TO PATIENTS 175, 833, 040 271, 683, 829 447, 516, 869 0.071801 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 14, 055, 530 36, 987, 081 51, 042, 611 0.033404 0.000000 73.00 74.00 07400 RENAL DI ALYSIS 82, 176 2.081 84, 257 0.000973 0.000000 74.00 75.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 0.000000 75.00 77.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 0.000000 75.00 77.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 0.000000 75.00 77.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 0.000000 75.00 77.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 0.000000 75.00 0.000000 0.000000 0.000000 75.00 0.000000 0.		1	0	45 007 104	0			1
73.00 07300 DRUGS CHARGED TO PATIENTS 14,055,530 36,987,081 51,042,611 0.033404 0.000000 73.00 74.00 07400 RENAL DIALYSIS 82,176 2,081 84,257 0.000973 0.000000 75.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0.000000 0.000000 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0.000000 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0.000000 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0.000000 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0.000000 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0.000000 0.000000 0.000000 0.000000 78.00 07800 CAR T-CELL IMMUNDTHERAPY 0 0 0 0.000000			1					1
74. 00 07400 [RENAL DI ALYSIS] 75. 00 07500 ASC (NON-DI STINCT PART) 77. 00 07500 ASC (NON-DI STINCT PART) 78. 00 07500 ASC (NON-DI STINCT PART) 79. 00 07500 ASC (NON-DI STINCT PART) 79. 00 07500 ASC (NON-DI STINCT PART) 79. 00 07500 [ASC (NON-DI STINC			1					1
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0		07400 RENAL DI ALYSI S	82, 176	2, 081	84, 257			
78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0					
OUTPATI ENT SERVICE COST CENTERS			0					
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0			-	-	_	0.00000	3, 333333]
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0			0	0				
91. 00 09100 EMERGENCY 0 0 0 0 0.000000 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 585, 927 6, 434, 948 7, 020, 875 0.406084 0.000000 92. 00 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0.000000 0.000000 94. 00 95. 00 09500 AMBULANCE SERVICES 0 0 0 0.000000 0.000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0.000000 0.000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 0.000000 96. 00 98. 00 09850 OTHER REI MBURSABLE COSTS 0 0 0 0.000000 0.000000 97. 00 99. 10 09910 CMFC 0 0 0 0 0.000000 0.000000 99. 00 99. 10 09910 CORF 0 0 0 0 0.000000 0.000000 99. 00 100. 00 10000 LAR SERVICES-NOT APPRVD PRGM 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 105. 00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 110. 00		1	0	0			0 000000	1
92. 00		1 1	0	0				1
94. 00		09200 OBSERVATION BEDS (NON-DISTINCT PART	585, 927	6, 434, 948	7, 020, 875			1
95. 00	04.00			_	_	0.000000	0.000000	04.00
96. 00			0		i e			
97. 00		1	l o	Ö				
99. 00		1 1	0	0	0			1
99. 10			0	0	0	0. 000000	0. 000000	
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 102. 00 102.			0	0	0			
102. 00			0	Ö	1			
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 106.00 106.00 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 107.00 109.00 109.00 109.00 107.00 109		1	0					
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 110. 00	102.00		0	0	0			102.00
106. 00 106.00 107. 00 107.00 107. 00 107.00 108. 00 108. 00 108. 00 108. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 0 109. 00 0 110. 00 109. 00 110. 00 0 110. 00 0 110. 00 0 110. 00 0	105 00			0	0			105 00
107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00								
109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 110. 00 1 100. 0 0 0 110. 00 110. 00 1 110. 00 1 100. 00 1 110. 00 1	107.00	10700 LIVER ACQUISITION	0	0	0			107. 00
110.00 11000 INTESTINAL ACQUISITION 0 0 0 1110.00			0	0	0			
			0	0				
				0	1			111.00
113. 00 11300 I NTEREST EXPENSE 113. 00	113.00	11300 INTEREST EXPENSE]					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00	114.00	0 11400 UTILIZATION REVIEW-SNF						114.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER				In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 01/01/2023	Worksheet C		
				To 12/31/2023	Date/Time Pre	pared:	
					5/30/2024 1: 3	88 pm	
		Title	XVIII	Hospi tal	PPS		
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA		
			+ col. 7)	Ratio	I npati ent		
					Ratio		
	6. 00	7.00	8. 00	9. 00	10.00		
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00	
116. 00 11600 HOSPI CE	0	0		0		116.00	
200.00 Subtotal (see instructions)	318, 650, 592	781, 974, 112	1, 100, 624, 70	14		200. 00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	318, 650, 592	781, 974, 112	1, 100, 624, 70	14		202. 00	

			Title XVIII	Hospi tal	5/30/2024 1: 38 PPS	s pm
	Cost Center Description	PPS Inpatient	THE XVIII	поэрг саг	110	
	F	Ratio				
		11. 00				
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT					30. 00 31. 00
31. 00	02060 NEONATAL INTENSIVE CARE UNIT	1				31.00
32. 00	03200 CORONARY CARE UNIT	1				32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT					34.00
40.00	04000 SUBPROVI DER - I 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	04600 OTHER LONG TERM CARE					46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 105815				50. 00
51.00	05100 RECOVERY ROOM	0. 103813				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00	05300 ANESTHESI OLOGY	0. 002624				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 057565				54.00
54. 01	03630 ULTRA SOUND	0. 250563				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. 000000				57.00
58. 00	05800 MRI	0. 000000				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 046681				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60.01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000 0. 000000				61. 00 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 RESPI RATORY THERAPY	0. 059269				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 179173				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. 018096				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 028913				71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 071801				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 033404				73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0. 000973				74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000 0. 000000				75. 00 77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000				70.00
88. 00	08800 RURAL HEALTH CLINIC					88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00	09000 CLI NI C	0. 000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 406084				92.00
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000				94.00
	09500 AMBULANCE SERVICES	0.000000				95.00
	O9600 DURABLE MEDI CAL EQUI P-RENTED O9700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000 0. 000000				96. 00 97. 00
	09850 OTHER REIMBURSABLE COSTS	0. 000000				98.00
	09900 CMHC	0.000000				99.00
	09910 CORF					99. 10
	10000 &R SERVICES-NOT APPRVD PRGM				1	100.00
	10100 HOME HEALTH AGENCY					101.00
102.00	10200 OPIOID TREATMENT PROGRAM				[1	102.00
	SPECIAL PURPOSE COST CENTERS					
	10500 KIDNEY ACQUISITION					105.00
	10600 HEART ACQUISITION					106.00
	10700 LIVER ACQUISITION					107.00
	10800 LUNG ACQUI SI TI ON					108.00
	10900 PANCREAS ACQUISITION					109.00
	11000 I NTESTI NAL ACQUI SI TI ON					110.00
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE					111.00
						113. 00 114. 00
	111400 OTTLIZATION REVIEW-SNF					114.00 115.00
	11600 HOSPI CE					116.00
	Total Control	1			l'	

		LUTHERAN MUSCULOSK	ELETAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 1:3	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
200.00	Subtotal (see instructions)					200.00
201. 00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

COMPU ⁻	TATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0168	Period: From 01/01/2023	Worksheet C Part I Date/Time Pre 5/30/2024 1:3	pared:
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	LANDATI DILIT DOLLTI NE OEDINI OF COOT OFFITEDO	1. 00	2.00	3. 00	4. 00	5. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 369, 902		8, 369, 902	2 0	8, 369, 902	30.00
31. 00	03100 INTENSIVE CARE UNIT	0			o o		1
31. 01	02060 NEONATAL INTENSIVE CARE UNIT	0			0	0	31.01
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0				0	32. 00 33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			o o	ő	34.00
40.00	04000 SUBPROVI DER - I PF	0			0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0				0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			o o	ő	44.00
45.00	04500 NURSING FACILITY	0		(0	l .	45.00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0			0	0	46.00
50.00	05000 OPERATING ROOM	33, 782, 756		33, 782, 756	5 0	33, 782, 756	50.00
51.00	05100 RECOVERY ROOM	6, 160, 017		6, 160, 01			1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	79, 355		79, 355	-		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 637, 941		1, 637, 94		l	
54. 01	03630 ULTRA SOUND	4, 118		4, 118		1	54. 01
55. 00 56. 00	O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OI SOTOPE	0			0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0				0	57.00
58. 00	05800 MRI	0			0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		((0.05)	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	662, 256		662, 250	0	662, 256 0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			o o	ő	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	39, 190	0	39, 190		39, 190	•
66.00	06600 PHYSI CAL THERAPY	10, 362, 520	0	10, 362, 520	0	1	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00 68. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	42, 222	U	42, 22		42, 222	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2, 030, 838		2, 030, 838		_, -, ,	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	32, 132, 216 1, 705, 005		32, 132, 216 1, 705, 005		32, 132, 216 1, 705, 005	
	07400 RENAL DI ALYSI S	82		82			74.00
	07500 ASC (NON-DISTINCT PART)	0			0	0	
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	l	
	OUTPATIENT SERVICE COST CENTERS	_			-	_	
88. 00 89. 00		0		1	0 0	l	88. 00 89. 00
	09000 CLINIC	0				0	ı
91.00	09100 EMERGENCY	0			o o		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 851, 062		2, 851, 062	2	2, 851, 062	92.00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0			0	0	94.00
95. 00	l l	0		1	o o		
96.00	l l	0			0		
	09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COSTS	0			0	0	97. 00 98. 00
	09900 CMHC	0				ő	•
	09910 CORF	0				0	
	10000 1&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0)	l	100. 00 101. 00
	10200 OPIOID TREATMENT PROGRAM	0				l e	102.00
	SPECIAL PURPOSE COST CENTERS	_			_ I	_	
) 10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0		•))		105. 00 106. 00
	10700 LIVER ACQUISITION			•	Ď	0	107.00
	10800 LUNG ACQUISITION	0					108.00
)10900 PANCREAS ACQUISITION)11000 INTESTINAL ACQUISITION	0			7		109. 00 110. 00
111.00	11100 ISLET ACQUISITION				Ó	•	111.00
113.00	11300 I NTEREST EXPENSE			1			113. 00

Health Financial Systems	UTHERAN MUSCULO	SKELETAL CENTER	?	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 99, 859, 480 2, 851, 062 97, 008, 418		2, 851, 06	2		201. 00

Health Financial Systems

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

					0 12/31/2023	5/30/2024 1: 3	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
		6. 00	7. 00	8.00	9.00	Ratio 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	03000 ADULTS & PEDIATRICS	8, 675, 321		8, 675, 321			30.00
	03100 INTENSIVE CARE UNIT	0		0			31.00
	02060 NEONATAL INTENSIVE CARE UNIT	0		0			31.01
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0			32. 00 33. 00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
	04000 SUBPROVI DER - I PF	O		0			40.00
	04100 SUBPROVI DER - I RF	0		0			41.00
	04300 NURSERY	0		0			43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0					44. 00 45. 00
	04600 OTHER LONG TERM CARE						46.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>					10.00
	05000 OPERATING ROOM	63, 306, 863	255, 955, 962			0. 000000	
	05100 RECOVERY ROOM	7, 770, 265	55, 280, 568			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	8, 298, 827	21, 944, 815	0 30, 243, 642		0. 000000 0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	3, 298, 469	25, 155, 284			0. 000000	
	03630 ULTRA SOUND	15, 056	1, 379	1		0. 000000	1
	05500 RADI OLOGY-THERAPEUTI C	0	0	0		0. 000000	1
	05600 RADI OI SOTOPE	0	0	0		0.000000	
	05700 CT SCAN 05800 MRI	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
	05900 CARDI AC CATHETERI ZATI ON		0		0. 000000	0. 000000	
	06000 LABORATORY	6, 573, 504	7, 613, 431	14, 186, 935		0. 000000	
	06001 BLOOD LABORATORY	0	0	0	0. 000000	0. 000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
	06400 INTRAVENOUS THERAPY	0	0		1	0. 000000	
	06500 RESPIRATORY THERAPY	452, 300	208, 925	661, 225		0. 000000	
	06600 PHYSI CAL THERAPY	3, 670, 399	54, 164, 817	57, 835, 216		0. 000000	1
	06700 OCCUPATI ONAL THERAPY	0	0	0		0.000000	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	799, 473	1, 533, 808	2, 333, 281	0. 000000 0. 018096	0. 000000 0. 000000	1
	07000 ELECTROENCEPHALOGRAPHY	777, 473	1, 333, 600	2, 333, 201	0. 000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 233, 442	45, 007, 184	70, 240, 626		0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	175, 833, 040	271, 683, 829			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	14, 055, 530	36, 987, 081			0.000000	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	82, 176	2, 081 0	1		0. 000000 0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		1	0. 000000	
	07800 CAR T-CELL IMMUNOTHERAPY	O	0	Ō	1	0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	•		0.000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	1		0. 000000 0. 000000	
	09100 EMERGENCY	l o	Ö	Ö	1	0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	585, 927	6, 434, 948	7, 020, 875	0. 406084	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1	-	-	0.00005	0.00005	04.55
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	0	l .		0. 000000 0. 000000	
	09600 DURABLE MEDICAL EQUIP-RENTED		0	0		0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	O	0	Ō		0. 000000	
	09850 OTHER REIMBURSABLE COSTS	0	0	0	0. 000000	0. 000000	
	09900 CMHC	0	0	0			99.00
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0			99. 10 100. 00
	10100 HOME HEALTH AGENCY	0	0				100.00
	10200 OPI OI D TREATMENT PROGRAM	O	0				102.00
	SPECIAL PURPOSE COST CENTERS						
	10500 KI DNEY ACQUI SI TI ON	0	0			0.000000	1
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	0			0. 000000 0. 000000	1
	10800 LUNG ACQUISITION		0	0	1	0. 000000	
	10900 PANCREAS ACQUISITION	O	0	Ö	0. 000000	0. 000000	1
	11000 INTESTINAL ACQUISITION	0	0	0		0. 000000	1
	11100 SLET ACQUISITION	0	0	0	0. 000000	0. 000000	
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
114.00	THOO OTHER ZATION REVIEW-SIN	<u> </u>		1	<u> </u>		11 17.00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER				In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2023	Worksheet C Part I		
				To 12/31/2023		epared: 38 pm	
		Ti tl	e XIX	Hospi tal	Cost		
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA		
			+ col. 7)	Ratio	I npati ent		
					Ratio		
	6. 00	7. 00	8. 00	9. 00	10.00		
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00	
116. 00 11600 HOSPI CE	0	0		0		116.00	
200.00 Subtotal (see instructions)	318, 650, 592	781, 974, 112	1, 100, 624, 70	4		200.00	
201.00 Less Observation Beds						201.00	
202.00 Total (see instructions)	318, 650, 592	781, 974, 112	1, 100, 624, 70	4		202. 00	

| Period: | Worksheet C | From 01/01/2023 | Part | | Date/Time Prepared: | 5/30/2024 | 1:38 pm | Hospital | Cost | Title XIX

		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT				31.01
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 - I 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. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54.01 03630 ULTRA SOUND	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI 01 SOTOPE	0. 000000			56.00
57.00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 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 RESPI RATORY THERAPY	1			65.00
	0.000000			
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			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
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0. 000000			105. 00
106. 00 10600 HEART ACQUISITION	0. 000000			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0. 000000			107.00
· · · · · · · · · · · · · · · · · · ·	1			
108. 00 10800 LUNG ACQUI SI TI ON	0.000000			108.00
109. 00 10900 PANCREAS ACQUISITION	0.000000			109.00
110. 00 11000 INTESTINAL ACQUISITION	0.000000			110.00
111. 00 11100 SLET ACQUI SI TI ON	0. 000000			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.)				115.00
116. 00 11600 HOSPI CE				116. 00

		LUTHERAN MUSCULOSK	ELETAL CENTER	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 1:3	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provi der C	CN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 1:3	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cos (col. 1 - col. 2)		Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 NEONATAL INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30 through 199) Cost Center Description	1, 103, 939 0 0 0 0 0 0 0 0 0 1, 103, 939 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 94 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	31.00 31.01 32.00 33.00 34.00 40.00 41.00 43.00
INDATIENT DOUTINE CEDVICE COCT CENTEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 31. 01 NEONATAL INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30 through 199)	943 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000				30.00 31.00 31.01 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 200.00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Form CMS-2						2552-10	
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-0168	Peri od:	Worksheet D	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre	pared:
						5/30/2024 1: 3	8 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 792, 270	319, 262, 825	0. 01187			50.00
51.00	05100 RECOVERY ROOM	679, 203	63, 050, 833	0. 01077	2 1, 941, 147	20, 910	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	563	30, 243, 642	0. 00001	9 2, 028, 805	39	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	371, 386	28, 453, 753	0. 01305	2 805, 419	10, 512	54.00
54.01	03630 ULTRA SOUND	10	16, 435	0. 00060	6, 694	4	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0. 00000	0	0	56.00
57. 00	05700 CT SCAN	0	0	0.00000		0	57.00
58. 00	05800 MRI	0	0	0.00000		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59.00
60.00	06000 LABORATORY	2, 734	14, 186, 935				
60. 01	06001 BLOOD LABORATORY	2, 734	14, 100, 733	0. 00000	· · · · · · · · · · · · · · · · · · ·	0	60.01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000	.0		61.00
62. 00			_	0. 00000	0	0	62.00
63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			0	63.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		_	
64.00	06400 NTRAVENOUS THERAPY	0	(/4 005	0.00000		0	64.00
65.00	06500 RESPI RATORY THERAPY	98	661, 225				
66.00	06600 PHYSI CAL THERAPY	2, 208, 869	57, 835, 216		· ·		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0. 00000			67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	106	2, 333, 281	0. 00004		l .	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 054	70, 240, 626				
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	357, 280	447, 516, 869			35, 252	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 288	51, 042, 611	0. 00008		l .	
74.00	07400 RENAL DI ALYSI S	0	84, 257	0. 00000		0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0			0	75.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
90.00	09000 CLI NI C	0	0	0. 00000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0. 00000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	376, 038	7, 020, 875			10, 261	92.00
	OTHER REIMBURSABLE COST CENTERS		, , , , , , ,		, , , , , , , , , , , , , , , , , , , ,		
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94.00
95. 00	09500 AMBULANCE SERVICES			3. 23000			95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD) n	0. 00000		0	97.00
98. 00	09850 OTHER REIMBURSABLE COSTS		0	0.00000		0	98.00
200.00		7 913 900	1, 091, 949, 383		78, 034, 223	_	
200.00	Total (Tines 30 till bugil 177)	1,013,099	1,071,747,303	I	10,034,223	1 304, 193	₁ 200.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10		
ADDODTIONMENT OF INDATIENT POUTINE	SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0168	Pariod: Workshoot D		

Health Financial Systems	LUTHERAN MUSCULO:	SKELETAL CENTEI	R	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C	CN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part III	epared:
		Ti tl e	e XVIII	Hospi tal	PPS	о рііі
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	1'	
cost center bescription	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Education	
			Aujustillerits			
	Adjustments 1A	1.00	24	2. 00	3. 00	
INDATIENT DOUTINE CEDVICE COST CENTERS	IA IA	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					J 0	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0			0 0		
31.00 03100 INTENSIVE CARE UNIT	0		1	0 0		1
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	_	1	0	1	
32. 00 03200 CORONARY CARE UNIT	0	_	•	0 0	1	1
33.00 03300 BURN INTENSIVE CARE UNIT	0	0)	0) 0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0) 0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0 0	0	40.00
41. 00 04100 SUBPROVI DER - 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		44.00
45. 00 04500 NURSING FACILITY	0	0		0 0		45.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	,-	col . 6)		
		mi nus col . 4)		33.1 37		
	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, 66	0. 00	943	30.00
31.00 03100 INTENSIVE CARE UNIT		0		0.00	l .	1
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			1	0 0.00	1	1
32. 00 03200 CORONARY CARE UNIT			ł	0 0.00	l .	
33. 00 03300 BURN INTENSIVE CARE UNIT				0.00	l .	1
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T				0.00	1	1
40. 00 04000 SUBPROVI DER - I PF	0			0.00	1	1
			1		l .	1
	0	_	1	0.00	1	
43. 00 04300 NURSERY		0		0.00	1	
44.00 04400 SKILLED NURSING FACILITY		0	•	0.00	1	
45.00 04500 NURSING FACILITY		0		0.00		
200.00 Total (lines 30 through 199)		0	5, 66	53	943	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)	_				
INDATI ENT. POUTI NE CERVI CE COOT CENTERO	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	1				30.00
31.00 03100 INTENSIVE CARE UNIT	0	1				31. 00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	l .				31. 01
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	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0	l .				44.00
45. 00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00
	1	'				

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2023 | Part IV |
| To 12/31/2023 | Date/Time Prepared: | 5/30/2024 1:38 pm | THROUGH COSTS

					12,01,2020	5/30/2024 1: 3	8 pm
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C)	0	0	50.00
51.00	05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	54.00
54.01	03630 ULTRA SOUND	0	C		0 0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	o	C		0 0	0	56.00
57.00	05700 CT SCAN	o	C		0 0	0	57.00
58. 00	05800 MRI	0	Ċ		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ċ		0 0	0	59.00
60.00	06000 LABORATORY	0	Č		0 0	•	60.00
60. 01	06001 BLOOD LABORATORY				0 0	-	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1		Ĭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0				•	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0			0 0	1	64.00
65. 00	06500 RESPIRATORY THERAPY	0			0 0	1	65.00
	I I	0			0 0	1	ł
66.00	06600 PHYSI CAL THERAPY	0			-	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	2	0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	C	2	0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	2	0 0	1	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C)	0	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	C		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C)	0	_	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C)	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	C)	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C		0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0	89. 00
90.00	09000 CLI NI C	0	C		0	0	90.00
91.00	09100 EMERGENCY	O	C		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0	C		0 0	0	94.00
95. 00	09500 AMBULANCE SERVICES						95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	l o	C	ol	0 0	0	96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	1	Ċ		0 0	•	97.00
98. 00	09850 OTHER REIMBURSABLE COSTS	1 0	Ċ		0 0	1	98.00
200.00	i i		C		0 0	_	200.00
200.00	, 1.5ta. (111105 00 till bugil 177)	١		1	٥,	1	_50.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Part IV | Par Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0168 THROUGH COSTS

					0 12/31/2023	5/30/2024 1:3	
			Title	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
	1	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				010 010 005	0.00000	
50.00	05000 OPERATING ROOM	0	0				
51.00	05100 RECOVERY ROOM	0	0			0. 000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C		0. 000000	1
53.00	05300 ANESTHESI OLOGY	0	0	C		0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C		0. 000000	
54. 01	03630 ULTRA SOUND	0	0	· ·		0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0.000000	
57.00	05700 CT SCAN	0	0	· ·	_	0.000000	57.00
58.00	05800 MRI	0	0		1	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0			0.000000	59.00
60.00	06000 LABORATORY	U	0			0.000000	60.00
60. 01	06001 BLOOD LABORATORY	U	Ü	١	0	0. 000000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	,		0.000000	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	·	0	0.000000	62. 00 63. 00
64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0. 000000 0. 000000	64.00
65. 00	06500 RESPIRATORY THERAPY	0	0		661, 225	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0	0			0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0			0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		1	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0.000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0. 000000	73.00
74. 00	07400 RENAL DIALYSIS	0	0		,-,	0. 000000	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0			0. 000000	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0. 000000	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	9			,	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0			0.000000	
90.00	09000 CLI NI C	O	0		0	0.000000	90.00
91.00	09100 EMERGENCY	0	0	Ċ	0	0.000000	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	-1					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0.000000	94.00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0.000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0	[C	0	0. 000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COSTS	0	0	(0	0.000000	98. 00
200.00	Total (lines 50 through 199)	0	0	0	1, 091, 949, 383		200. 00

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

From 01/01/2023 To 12/31/2023 Part IV Date/Time Prepared: THROUGH COSTS 5/30/2024 1:38 pm Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Charges Pass-Through Charges (col. 6 ÷ Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) col. 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 15, 760, 482 34, 782, 391 50 00 0 51.00 05100 RECOVERY ROOM 0.000000 1, 941, 147 7, 807, 353 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 2,028,805 0 2, 605, 897 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0.000000 805, 419 1, 981, 322 0 54.00 54.01 03630 ULTRA SOUND 0.000000 6,694 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 05600 RADI OI SOTOPE 0 56.00 0.000000 0 0 56.00 Ω 0 57.00 05700 CT SCAN 0.000000 C 0 0 57.00 58.00 05800 MRI 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 59.00 0 06000 LABORATORY 0.000000 1, 853, 061 0 1, 490, 765 60.00 60.00 0 60.01 06001 BLOOD LABORATORY 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 62.00 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 0 06500 RESPIRATORY THERAPY 0.000000 89, 904 25, 134 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.000000 978, 828 320, 298 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0.000000 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0.000000 254, 266 0 382, 243 Ω 69 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 6, 557, 873 5, 824, 268 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.000000 44, 175, 227 44, 375, 986 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0.000000 3, 355, 712 0 4, 666, 918 0 73 00 07400 RENAL DIALYSIS 74.00 0.000000 35, 218 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 0 ol 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 Ω 0 Ω OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89.00 0 90.00 09000 CLI NI C 0.000000 90.00 C 0 0 0 91.00 09100 EMERGENCY 0.000000 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 191, 587 0 1, 181, 290 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 n 0 0 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96.00 96.00 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 Ω 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COSTS 0.000000 0 98.00 200.00 Total (lines 50 through 199) 78, 034, 223 105, 443, 865 0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0168 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 1:38 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 105815 34, 782, 391 3, 680, 499 50.00 05100 RECOVERY ROOM 0 0 0.097699 51.00 7, 807, 353 51.00 762, 771 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.002624 2, 605, 897 0 0 6,838 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.057565 1, 981, 322 0 114, 055 54.00 0 03630 ULTRA SOUND 0. 250563 0 54 01 54.01 Ω 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 C 0 55.00 56.00 05600 RADI 0I SOTOPE 0.000000 0 0 0 0 56.00 0 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 05800 MRI 0.000000 58.00 C 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 06000 LABORATORY 0 69, 590 60.00 0.046681 1, 490, 765 0 0 60.00 06001 BLOOD LABORATORY 0 60 01 0.000000 60 01 0 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 62.00 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 0 0 0 06400 I NTRAVENOUS THERAPY 0 64 00 0.000000 0 64 00 06500 RESPIRATORY THERAPY 0 65.00 0.059269 25, 134 1,490 65.00 06600 PHYSI CAL THERAPY 0.179173 320, 298 0 57, 389 66.00 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 0.000000 C 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68 00 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.018096 382, 243 6, 917 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 168, 397 71.00 0.028913 5, 824, 268 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 44, 375, 986 0 0 3, 186, 240 72 00 0.071801 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.033404 4, 666, 918 0 559 155, 894 73.00 07400 RENAL DIALYSIS 74.00 0.000973 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75 00 0.000000 75.00 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 09100 EMERGENCY 0.000000 0 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 181, 290 479, 703 92.00 0.406084 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0. 000000 94.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0.000000 C 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COSTS 0.000000 98.00 0 Subtotal (see instructions) 105, 443, 865 0 8, 689, 783 200. 00 200.00 559

0

0

559

105, 443, 865

201.00

8, 689, 783 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Period: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Time Prepared:

Cost Center Description					10 12/01/2020	5/30/2024 1: 3	38 pm
Cost Center Description			Title	XVIII	Hospi tal		
Rel imbursed Services Subject To Ded & Coins Services Subject To Ded & Coins Services Not Subject To Ded & Coins Ded & Coins Subject To Ded & Coins		Costs	5				
Rel imbursed Services Subject To Ded & Coins Services Subject To Ded & Coins Services Not Subject To Ded & Coins Ded & Coins Subject To Ded & Coins	Cost Center Description	Cost	Cost				
Services Subject To Ded. & Coins.	· ·	Rei mbursed	Reimbursed				
Subject To Ded. & Coins. Subject To Ded. & Coins. See Inst.) Subject To Ded. & Coins. See Inst.) See Inst.) See Inst.		Services S	ervices Not				
Decl. & Colins. Cose Inst. See Ins							
See Inst. See							
MACI LLARY SERVICE COST CENTERS							
MACILLARY SERVICE COST CENTERS							
50.00 050000 0FEATI NG ROOM 0 0 0 51.00 51	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
51.00 05100 RECOVERY ROOM 55.00 55.00 55.00 55.00 052.00		0	0				50.00
S2.00 OS200 OSE200 OSE		1	- 1				
53.00 05300 AIRSTHESI OLOGY 0 0 54.00 54.00 05400 RADIOLOGY-OI JAKONSTIC 0 0 0 54.00 54.01 03630 ULTRA SOUND 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTI C 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 55.00 58.00 05500 RADIOLOGY-THERAPEUTI C 0 0 0 55.00 58.00 05500 URSIO CATHETERI ZATI ON 0 0 0 55.00 59.00 05590 CARDIOLOG CATHETERI ZATI ON 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 60.01 06001 BLODO LABORATORY 0 0 0 0 61.00 06000 HOLOG BLODO & PACKED RED BLODO CELL 0 0 0 0 62.00 06200 WHOLE BLODO & PACKED RED BLODO CELL 0 0 0 0 63.00 06300 HOLOG BLODO & PACKED RED BLODO CELL 0 0 0 0 64.00 06400 ITRAVENDIST HERAPY 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 06500 PHYSI CAL THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 0 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 70.00 07000 DELOGRAM DIALYSIS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0 0 70.00 07000 RELANCED TO PATI ENTS 0 0		1					
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1.57		1	- 1				1
S8. 00 OSBOO MRI		1	0				1
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57. 00 05700 CT SCAN	0	0				57.00
60.00 06000 06000 1800	58. 00 05800 MRI	0	0				58.00
60.01 06001 06100 PBP CLI NI CAL LAB SERVICES-PREM ONLY 0 0 06100 PBP CLI NI CAL LAB SERVICES-PREM ONLY 0 0 06200 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 063.00 06300 06300 06300 06300 06300 06300 06300 06300 06300 06300 06300 06300 06300 064.00 064.00 064.00 064.00 064.00 064.00 064.00 064.00 066.00	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.01 0600	60. 00 06000 LABORATORY	0	ol				60.00
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72. 00 07200 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 19 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 88. 00 08800 RURAL HEALTH CLINIC 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 90. 00 09900 CLINIC 90. 00 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0THER REIMBURSABLE COST CENTERS 94. 00 95. 00 09500 MBULANCE SERVICES 0 96. 00 09500 MBULANCE SERVICES 0 97. 00 09700 DURABLE MEDICAL EQUIP-RENTED 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 98. 00 09850 OTHER REIMBURSABLE COSTS 0 99. 00 00 00 00 00 00 00 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
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Only Charges		1	19				1
	201.00 Less PBP Clinic Lab. Services-Program	0					201.00
202.00 Net Charges (line 200 - line 201) 0	Only Charges						
	202.00 Net Charges (line 200 - line 201)	0	19				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0168 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 1:38 pm Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 208, 603 0. 105815 50.00 05100 RECOVERY ROOM 0 0.097699 51.00 0 226, 981 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0.002624 0 0 132, 689 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.057565 0 127, 093 54.00 0 03630 ULTRA SOUND 0. 250563 54.01 0 0 54.01 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 0 0 0 55.00 56.00 05600 RADI 0I SOTOPE 0.000000 0 0 56.00 0 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 0 05800 MRI 0.000000 58.00 58.00 C 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59.00 06000 LABORATORY 60.00 0.046681 36, 276 0 60.00 06001 BLOOD LABORATORY 0.000000 60 01 0 0 60 01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64 00 0.000000 0 0 64 00 0 06500 RESPIRATORY THERAPY 0 65.00 0.059269 0 0 65.00 06600 PHYSI CAL THERAPY 0.179173 0 216, 167 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 0 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 0.000000 68.00 68.00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.018096 3,584 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.028913 88, 165 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 0.071801 831, 481 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.033404 0 348, 667 0 73.00 07400 RENAL DIALYSIS 74.00 0.000973 0 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75 00 0.000000 0 0 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0.000000 0 0 0 O 90.00 09100 EMERGENCY 0.000000 0 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0.406084 0 10, 686 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 95.00 0.000000 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0.000000 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COSTS 0.000000 0 98.00 0 0 200.00 Subtotal (see instructions) 3, 230, 392 0 200, 00 C

201.00

0 202.00

0

3, 230, 392

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:38 pm

				12,01,2020	5/30/2024 1:3	38 pm
		Title	XIX	Hospi tal	Cost	
	Cos	ts				
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				ŀ
ANCLLL ADV. SEDVI CE. COST. CENTEDS	0.00	7.00				
ANCILLARY SERVICE COST CENTERS		107.000				
50. 00 05000 OPERATI NG ROOM	0	127, 888				50.00
51. 00 05100 RECOVERY ROOM	0	22, 176				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	348				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 316				54.00
54. 01 03630 ULTRA SOUND	O	o				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	ol	o				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57. 00 05700 CT SCAN		0				57.00
58. 00 05800 MRI		0				58.00
		0				59.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0					1
60. 00 06000 LABORATORY	0	1, 693				60.00
60. 01 06001 BL00D 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 RESPI RATORY THERAPY	O	O				65.00
66. 00 06600 PHYSI CAL THERAPY	o	38, 731				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY		o				68.00
69. 00 06900 ELECTROCARDI OLOGY		65				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				70.00
		-1				
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		2, 549				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	59, 701				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	11, 647				73. 00
74.00 07400 RENAL DI ALYSI S	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLI NI C	o	0				90.00
91. 00 09100 EMERGENCY		0				91.00
· · · · · · · · · · · · · · · · · · ·		-1				
	U_	4, 339				92.00
OTHER REIMBURSABLE COST CENTERS		0				
94. 00 09400 HOME PROGRAM DIALYSIS	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	O				98.00
200.00 Subtotal (see instructions)	O	276, 453				200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	o	276, 453				202.00
	١	270, 100				1-02.00

Heal th	Financial Systems LUTHERAN MUSCULOSKEL	ETAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od:	Worksheet D-1	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
		Title XVIII	Hospi tal	PPS	о рііі
	Cost Center Description		110001 101		
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days			5, 663	1.00
2. 00	Inpatient days (including private room days, excluding swing-b			5, 663	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	rs). If you have only pr	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			3, 734	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	r 31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	g swing-bed and	943	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	nly (İncluding private ı	room days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX lafter December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
	Total nursery days (title V or XIX only)	iii (excluding swing-bed	uays)	0	
16. 00	Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	of the 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 December 31 of	f the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of	the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	.)		8, 369, 902	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ting period (line		ł
23. 00	5 x line 17) 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) Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00

	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 663	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 734	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	U	8.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	943	9. 00
7. 00	newborn days) (see instructions)	743	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
	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 services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
.0.00	reporting period	0.00	.0.00
19.00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
	Total general inpatient routine service cost (see instructions)	8, 369, 902	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	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
20.00	I in e 20)	o o	20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 369, 902	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
	Private room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
			32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
	Private room cost differential adjustment (line 3 x line 35)	0 240 002	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 369, 902	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 478. 00	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	1, 393, 754	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 373, 734	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 393, 754	

Heal th	Financial Systems LU	THERAN MUSCULOS	KELETAL CENTER	?	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/30/2024 1:3	pared:
	Cost Center Description	Total I npati ent Cost 1.00	Title Total Inpatient Days 2.00	Average Per Diem (col. ÷ col. 2)		PPS Program Cost (col. 3 x col. 4) 5.00	
42. 00	NURSERY (title V & XIX only)	0	0				42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	O	0. (00 0	0	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT	O	0	0. (00 0	0	43. 01
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. (0. (0 0	1
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. (0	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	·					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10) column 1)	5, 733, 882 0	1
49. 00	, , , , , , , , , , , , , , , , , , , ,	•			o, coramir r)	7, 127, 636	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sı	um of Parts I and	183, 828	50.00
51. 00		atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	304, 195	51.00
52.00	Total Program excludable cost (sum of lines					488, 023	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	/sician anest	chetist, and	6, 639, 613	53.00
54.00	Program di scharges					0	54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 55				11 50)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	s line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	d ending 1996,	0.00	
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year o	cost report,	updated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	which operati	ng costs (line	0	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Doos	mbox 21 of the	a agat manani	ing ported (Coo	0	64.00
04.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece	iliber 31 Of the	; cost report	Trig perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reportin	ng period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	55)(title XVI	<pre>II only); for</pre>	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 d	of the cost r	reporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	porting period	0	
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N Skilled pursing facility/other pursing facility/	URSING FACILITY	, AND ICF/IID	ONLY	7)	0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00
72.00	Program routine service cost (line 9 x line	71)		•			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv		•				73.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78.00							78.00
79.00	Aggregate charges to beneficiaries for exces	, ,		,	nue line 70)		79.00
00 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust iimitatior	ı (ııne /8 mi	nus iine 79)		80. 00 81. 00
80. 00 81. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
81. 00 82. 00			C 1			1	83.00
81. 00 82. 00 83. 00	Reasonable inpatient routine service costs (5)				1
81. 00 82. 00 83. 00 84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation	structions) (see instructio	ns)				84. 00 85. 00
81. 00 82. 00 83. 00 84. 00 85. 00	Program inpatient ancillary services (see in	structions) (see instructio of lines 83 th	ns)				84.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	!	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			1, 478. 00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			2, 851, 062	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	1, 103, 939	8, 369, 902	0. 13189	4 2, 851, 062	376, 038	90.00
91.00 Nursing Program cost	0	8, 369, 902	0.00000	0 2, 851, 062	0	91.00
92.00 Allied health cost	0	8, 369, 902	0.00000	0 2, 851, 062	0	92.00
93.00 All other Medical Education	0	8, 369, 902	0. 00000	2, 851, 062	0	93.00

Heal th	Financial Systems	LUTHERAN MUSCULOSKEI	LETAL CENTER	In Lie	u of Form CMS-2	552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN: 15-0168	Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 1:38	oared: 3 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room d	lays and swing-bed day:	s, excluding newborn)		5, 663	1.00
2.00	Inpatient days (including private room d	lays, excluding swing-l	ped and newborn days)		5, 663	2.00
3. 00	Private room days (excluding swing-bed a do not complete this line.	and observation bed day	ys). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-	bed and observation be	ed days)		3, 734	4.00

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 663	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 734	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	_	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	323	9. 00
40.00	newborn days) (see instructions)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
10.00	reporting period	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0. 00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
21 00	reporting period	0.240.002	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	8, 369, 902	21. 00 22. 00
22.00	5 x line 17)	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
25.00	Swing-bed cost applicable to writing believes after beceined 31 of the cost reporting period (fine 8)	U	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)	8, 369, 902	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0 340 003	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8, 369, 902	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM I NPATI ENT OPERATI NG COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 478. 00	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	477, 394	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	477 204	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	477, 394	41.00

	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	323	9. 00
9.00	newborn days) (see instructions)	323	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	
12.00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10 00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	8, 369, 902	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x line 17)	ĭ	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 369, 902	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
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)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33. 00 34. 00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34. 00 35. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	36.00
37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	-	
37.00	27 minus line 36)	0, 309, 902	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		1, 478. 00	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	477, 394	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	477, 394	
		'	

111 +-	Figure in Contains	THEDAN MUCCULOC	VELETAL CENTE	·D	l = 1; -		2552 40
	Financial Systems LUT ATION OF INPATIENT OPERATING COST	THERAN MUSCULOS		CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet D-1	
00 01			1.07.40.	10 0100	From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpati ent	Total Inpatient	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)	•	col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	0	(0.	00 0	0	43.00
43. 01	NEONATAL INTENSIVE CARE UNIT	0		0.		0	
44.00	CORONARY CARE UNIT	0		0.		0	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0.		0	
	OTHER SPECIAL CARE (SPECIFY)		`]	00	Ĭ	47. 00
	Cost Center Description	·		•			
49.00	Program inpatient ancillary service cost (Wk	c+ D 2 col 2	Line 200)			1. 00 151, 983	48. 00
48. 00 48. 01	Program inpatient cellular therapy acquisition			: III. line 10). column 1)	131, 963	1
49. 00	Total Program inpatient costs (sum of lines	•				629, 377	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpulli)	atient routine	services (fro	om Wkst. D, si	um of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	О	51.00
	and IV)		- `	·			
52. 00 53. 00	Total Program excludable cost (sum of lines I Total Program inpatient operating cost exclu		lated non a	weician ance:	thatist and	0	
55.00	medical education costs (line 49 minus line	5 1	латей, поп-рг	iyərci an anes	inetist, dilu		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55	· ·				0	
57. 00 58. 00	Difference between adjusted inpatient operat	ing cost and ta	irget amount ((line 56 minus	s line 53)	0	
59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rea	ortina perio	d endi na 1996.	0.00	
	updated and compounded by the market basket)		•	0 .			
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year	cost report,	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than	the Lowest of	flines 55 plus	0	61.00
	55.01, or line 59, or line 60, enter the less	ser of 50% of t	he amount by	which operati	ng costs (line		
	53) are less than expected costs (lines 54 x	60), or 1 % of	the target a	mount (line !	56), otherwise		
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST			<u> </u>			
64.00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of tr	ne cost repor	ting period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporti	ng period (See	0	65.00
	instructions)(title XVIII only)			(=) (\nu			
66.00	Total Medicare swing-bed SNF inpatient routil CAH, see instructions	ne costs (line	64 plus line	65)(title XV	II only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost i	reporting period	0	67.00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost re	porting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		0	69.00
70	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY	7)		70
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				()		70.00
71.00	Program routine service cost (line 9 x line		THE 70 - TIME)			72.00
73.00	Medically necessary private room cost applications	abĺe to Program					73. 00
74.00	Total Program general inpatient routine serv	•		•	Dant II. aaluma		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	worksneet B,	Part II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		rovider recor	rds)			78. 00 79. 00
80.00	Total Program routine service costs for compa				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on			•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I						82. 00 83. 00
84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		13)				84.00
85. 00	Utilization review - physician compensation	,	ns)				85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86.00
87 NN	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1 929	87.00
		,				1,727	

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	!	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			1, 478. 00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			2, 851, 062	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	1, 103, 939	8, 369, 902	0. 13189	4 2, 851, 062	376, 038	90.00
91.00 Nursing Program cost	0	8, 369, 902	0.00000	0 2, 851, 062	0	91.00
92.00 Allied health cost	0	8, 369, 902	0.00000	0 2, 851, 062	0	92.00
93.00 All other Medical Education	0	8, 369, 902	0. 00000	2, 851, 062	0	93.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2023	Worksheet D-3	
		To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Co	st Innatient	Innatient	

				To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description	•	Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
					col . 2)	
	DATI ENT. DOUTINE OFFICE OF COOT OFFITEDS		1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS			0.100.010		
1	000 ADULTS & PEDIATRICS			2, 180, 348		30.00
1	100 INTENSIVE CARE UNIT			0		31. 00 31. 01
	060 NEONATAL INTENSIVE CARE UNIT 200 CORONARY CARE UNIT			0		31.01
	300 BURN INTENSIVE CARE UNIT					33. 00
4	400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
	000 SUBPROVI DER – I PF			0		40. 00
4	100 SUBPROVI DER – I RF			0		41. 00
	300 NURSERY					43.00
	CILLARY SERVICE COST CENTERS		'	·	•	
50.00 050	000 OPERATING ROOM		0. 10581	5 15, 760, 482	1, 667, 695	50.00
51.00 05	100 RECOVERY ROOM		0. 09769	9 1, 941, 147	189, 648	51.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52.00
	300 ANESTHESI OLOGY		0. 00262		5, 324	53.00
	400 RADI OLOGY-DI AGNOSTI C		0. 05756			54.00
1	630 ULTRA SOUND		0. 25056		1, 677	54. 01
	500 RADI OLOGY-THERAPEUTI C		0.00000		0	55.00
	600 RADI OI SOTOPE		0.00000		0	56.00
1	700 CT SCAN		0.00000		0	57.00
	800 MRI		0.00000			58.00
	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY		0. 00000 0. 04668		0 86, 503	59. 00 60. 00
	001 BLOOD LABORATORY		0.04666		00, 503	60. 00
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
1	200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		Ö	62. 00
1	300 BLOOD STORING, PROCESSING & TRANS.		0. 00000			63.00
	400 I NTRAVENOUS THERAPY		0. 00000		Ö	64.00
	500 RESPI RATORY THERAPY		0. 05926			65.00
1	600 PHYSI CAL THERAPY		0. 17917			66.00
67. 00 06 ⁻	700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67.00
68.00 068	800 SPEECH PATHOLOGY		0.00000	0 0	0	68.00
	900 ELECTROCARDI OLOGY		0. 01809		4, 601	69.00
	000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 02891			71.00
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 07180		3, 171, 825	72.00
	300 DRUGS CHARGED TO PATIENTS		0. 03340			73.00
	400 RENAL DIALYSIS 500 ASC (NON-DISTINCT PART)		0.00097		l I	74. 00 75. 00
	700 ALLOGENEIC HSCT ACQUISITION		0. 00000 0. 00000			77. 00
1	BOO CAR T-CELL IMMUNOTHERAPY		0.00000			78.00
	TPATIENT SERVICE COST CENTERS		0.00000	0 0	0	70.00
	800 RURAL HEALTH CLINIC		0.00000	ol	0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		Ö	89. 00
	DOO CLINIC		0.00000		0	90.00
91.00 09	100 EMERGENCY		0.00000	0 0	0	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 40608	4 191, 587	77, 800	92.00
	HER REIMBURSABLE COST CENTERS		,	_		
	400 HOME PROGRAM DIALYSIS		0.00000	0	0	94.00
	500 AMBULANCE SERVI CES					95.00
	600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	96. 00
	700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	97.00
1	OTHER REIMBURSABLE COSTS		0.00000		0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)	. (lin- (1)		78, 034, 223		
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charges Net charges (line 200 minus line 201)	s (iine 61)	1	78, 034, 223		201. 00 202. 00
202.00	INGL Charges (Title 200 millius Title 201)		I	10,034,223	I	202.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu	of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2023	Worksheet D-3

12/31/2023 Date/Time Prepared: 5/30/2024 1:38 pm Title XIX Hospi tal Cost I npati ent Cost Center Description Ratio of Cost Inpati ent To Charges Program Costs Program (col. 1 x Charges 2) 1.00 2.00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 163, 372 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 31.01 31.01 0 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0. 105815 666, 545 70, 530 50.00 05100 RECOVERY ROOM 51.00 0.097699 115, 164 11, 251 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.002624 104, 264 274 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.057565 97, 339 5,603 54.00 54 01 03630 ULTRA SOUND 0.250563 54.01 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 05600 RADI 0I SOTOPE 0.000000 0 56, 00 0 56.00 57.00 05700 CT SCAN 0.000000 0 57.00 0 58.00 05800 MRI 0.000000 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 59.00 06000 LABORATORY 60.00 0.046681 124, 785 5,825 60.00 60 01 06001 BLOOD LABORATORY 0.000000 Ω 60 01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 ol 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.059269 1, 458 86 65.00 06600 PHYSI CAL THERAPY 0.179173 66.00 46, 790 8, 384 66.00 06700 OCCUPATIONAL THERAPY 67 00 0.000000 0 67 00 0 06800 SPEECH PATHOLOGY 68.00 0.000000 Λ 68.00 69.00 06900 ELECTROCARDI OLOGY 0.018096 17, 608 319 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.028913 4, 185 144, 746 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.071801 515, 226 36, 994 72.00 07300 DRUGS CHARGED TO PATIENTS 0.033404 240, 783 8,043 73.00 74.00 07400 RENAL DIALYSIS 0.000973 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75 00 0.000000 75 00 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 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 91.00 0.000000 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 489 92.00 92.00 0.406084 1, 204 OTHER REIMBURSABLE COST CENTERS 0.000000 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COSTS 98.00 0.000000 0 200.00 Total (sum of lines 50 through 94 and 96 through 98) 2, 075, 912 151, 983 200. 00 201.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 202.00 202.00 Net charges (line 200 minus line 201) 2, 075, 912

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-255	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 1:38 pm

			10 12,01,2020	5/30/2024 1: 3	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				1. 00 1. 01
1. 02	<pre>instructions) DRG amounts other than outlier payments for discharges occurri instructions)</pre>	1, 630, 206	1. 02		
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl fo October 1 (see instructions)	or discharges occurring	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)				2.00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	one)		0	2. 01 2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (*		25, 062	2.03
2.04	Outlier payments for discharges occurring on or after October			15, 659	2. 04
3. 00	Managed Care Simulated Payments			7, 199, 938	3.00
4. 00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	32. 37	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	neriod ending on	0. 00	5.00
3.00	or before 12/31/1996. (see instructions)	recent cost reporting	perroa enaring on	0.00	3.00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the C	AA 2021 (see instructio	ns)	0. 00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the	e criteria for an add-c	n to the cap for	0. 00	6. 00
4 24	new programs in accordance with 42 CFR 413.79(e)		d under \$107 of	0.00	4 24
6. 26	Rural track program FTE cap limitation adjustment after the cathe CAA 2021 (see instructions)	ip-building window crose	a under §127 of	0. 00	6. 26
7. 00	MMA Section 422 reduction amount to the IME cap as specified u	under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0. 00	7. 01
	cost report straddles July 1, 2011 then see instructions.				
7. 02	Adjustment (increase or decrease) to the hospital's rural track programs with a rural track for Medicare GME affiliated and 87 FR 49075 (August 10, 2022) (see instructions)	1 3	` '	0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.		7.01, plus or	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year from your recor	ds		10.00
	FTE count for residents in dental and podiatric programs.				11.00
	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year.	r ended on or after Ser	tember 30 1997		13. 00 14. 00
00	otherwise enter zero.			0.00	
15.00	Sum of lines 12 through 14 divided by 3.				15. 00
	Adjustment for residents in initial years of the program (see	,			16.00
	Adjustment for residents displaced by program or hospital clos Adjusted rolling average FTE count	sure			17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4)			0. 000000	
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	•
22. 00	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside (f)(1)(iv)(C).		FR 412. 105	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 -O-, then enter the $\mbox{\it I}$	ower of line 23 or line	24 (see	0.00	25. 00
24 00	instructions)			0.000000	24 00
26.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
	IME add-on adjustment amount (see instructions)			0.000000	28.00
	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	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pa	tient dave (see instruc	tions)	2. 06	30.00
	Percentage of Medicaid patient days (see instructions)	itioni uays (SEE INSTIUC	0113)	0.00	
	Sum of lines 30 and 31				32.00
33. 00	Allowable disproportionate share percentage (see instructions)			0. 00	33.00

	Financial Systems LUTHERAN MUSCULOS ATION OF REIMBURSEMENT SETTLEMENT	SKELETAL CENTER Provider CCN: 15-0168		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/30/2024 1: 3 PPS	8 pm
		THE AVITE	nospi tai	113	
24 00	Disproportionate share adjustment (see instructions)			1. 00	34.00
34.00	prisproportionate share adjustment (see Tristructions)		Prior to 10/1		34.00
			1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		0	0	35.00
35. 01	Factor 3 (see instructions)		0. 00000000	0. 000000000	
35. 02	Hospital UCP, including supplemental UCP (see instructions)		0	0	
35. 03 36. 00	1		0	0	35. 03 36. 00
30. 00	Additional payment for high percentage of ESRD beneficiary				30.00
40. 00	Total Medicare discharges (see instructions)		0		40.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instru	usti ons)	0		41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	ed by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45.00
	Total additional payment (line 45 times line 44 times line	41. 01)	0		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	6, 422, 742		47. 00 48. 00
	only. (see instructions)	, smarr rarar nospitars	0		40.00
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ons)		6, 422, 742	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable		491, 012	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, I			0	
52. 00 53. 00				0	
54. 00	Special add-on payments for new technologies			0	1
54. 01	Islet isolation add-on payment	(0)		0	
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	e 69)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see in	ntructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, P. Total (sum of amounts on lines 49 through 58)	t. IV, col. II line 200)		0 6, 913, 754	
60.00	Pri mary payer payments			0, 710, 701	1
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		6, 913, 754	1
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			510, 356 0	62.00
	Allowable bad debts (see instructions)			491	1
	Adjusted reimbursable bad debts (see instructions)			319	1
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	nstructi ons)		0 6, 403, 717	
68. 00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs ((see instructions)	0, 403, 717	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96	• •	,	0	1
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	notrotion) odivotmont (coo	i notrusti ono)	0	1
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demon N95 respirator payment adjustment amount (see instructions)		: ITISTI ucti ons)	0	70. 50 70. 75
70. 87	Demonstration payment adjustment amount before sequestration	on		0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89 70. 90				0	70. 89 70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)	,		0	1
70. 92	Bundled Model 1 discount amount (see instructions)			0	1
70. 93	HVBP payment adjustment amount (see instructions)			0	
70 Q/	HRR adjustment amount (see instructions) 0 70.9				

Health Financial Systems LUTHERAN MUSC	CULOSKELETAL CENTER	R	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 1:3	pared:
	Title	XVIII	Hospi tal	PPS	- p
	<u> </u>	FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (I the corresponding federal year for the period prior to			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (I the corresponding federal year for the period ending of			0	0	70. 97
70.98 Low Volume Payment-3	,		0	0	70. 98
70.99 HAC adjustment amount (see instructions)			-	0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus	lines 69 & 70)			6, 403, 717	71.00
71.01 Sequestration adjustment (see instructions)	•			128, 074	71.01
71.02 Demonstration payment adjustment amount after sequestra	ation			0	71.02
71.03 Sequestration adjustment-PARHM pass-throughs					71.03
72.00 Interim payments				6, 275, 329	72.00
72.01 Interim payments-PARHM					72.01
73.00 Tentative settlement (for contractor use only)				0	73.00
73.01 Tentative settlement-PARHM (for contractor use only)					73.01
74.00 Balance due provider/program (line 71 minus lines 71.00 73)	1, 71.02, 72, and			314	74.00
74.01 Balance due provider/program-PARHM (see instructions)					74.01
75.00 Protested amounts (nonallowable cost report items) in a CMS Pub. 15-2, chapter 1, §115.2	accordance with			579, 418	75. 00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1		1
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, oplus 2.04 (see instructions)	or sum of 2.03			0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00 Operating outlier reconciliation adjustment amount (see	e instructions)			0	
93.00 Capital outlier reconciliation adjustment amount (see				0	1
94.00 The rate used to calculate the time value of money (see				0.00	
95.00 Time value of money for operating expenses (see instruc				0	
96.00 Time value of money for capital related expenses (see				0	
			Prior to 10/1	On/After 10/1	
			1.00	2. 00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment					
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00 HVBP adjustment amount for HSP bonus payment (see insti	ructions)		0	0	102.00
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instru	uctions)		o	0	104.00
Rural Community Hospital Demonstration Project (§410A [Demonstration) Adju]
200.00 Is this the first year of the current 5-year demonstra					200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.]
Cost Reimbursement					
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt.	II, line 49)				201.00
202.00 Medicare discharges (see instructions)					202.00
THE CONTRACT MIX adjustment factor (see instructions)			1		1000 AV

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0168		Worksheet E Part B Date/Time Prepared: 5/30/2024 1:38 pm	

		Title XVIII	Hospi tal	5/30/2024 1: 3: PPS	8 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	11		19	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments	tions)		8, 689, 783 9, 854, 288	1
4. 00	Outlier payment (see instructions)			153	
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6.00	Line 2 times line 5			0	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)	at araduata madi aal adu	antian agata from	0	
9. 00	Ancillary service other pass through costs including REH dire Wkst. D, Pt. IV, col. 13, line 200	ct graduate medical educ	cation costs from	0	9. 00
10.00	Organ acquisitions			o	10.00
	Total cost (sum of lines 1 and 10) (see instructions)			19	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
	Ancillary service charges			1	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			559	14.00
15. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable fo	. 3	0	o	
	had such payment been made in accordance with 42 CFR §413.13(G		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
	Total customary charges (see instructions)		44) (559	1
19. 00	Excess of customary charges over reasonable cost (complete on	Ty if line 18 exceeds li	ne 11) (see	540	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	lv if line 11 exceeds li	ne 18) (see	o	20.00
20.00	instructions)	Ty IT TITLE IT EXCECUS IT	110 10) (300		20.00
21.00	Lesser of cost or charges (see instructions)			19	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			9, 854, 441	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	c)		3, 220	25.00
	Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	1, 438, 814	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			8, 412, 426	1
	instructions)	•	- 1		
	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	REH facility payment amount (see instructions)			_	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 8, 412, 426	
	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			478	1
32. 00	Subtotal (line 30 minus line 31)			8, 411, 948	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			27, 385	
35.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	rusti ons)		17, 800 27, 343	
	Subtotal (see instructions)	ructions)		8, 429, 748	
	MSP-LCC reconciliation amount from PS&R			0, 127, 710	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
	N95 respirator payment adjustment amount (see instructions)			0	1
	Demonstration payment adjustment amount before sequestration		-+:>	0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ceu aevices (see instruc	ELLONS)	0	39. 98 39. 99
	Subtotal (see instructions)			8, 429, 748	1
40. 01	Sequestration adjustment (see instructions)			168, 595	1
	Demonstration payment adjustment amount after sequestration			0	1
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			8, 243, 797	
	Interim payments-PARHM			o	41.01
	Tentative settlement (for contractors use only)				
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			17, 356	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			17, 350	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	chapter 1,	o	1
	§115. 2				
0	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				93.00
	•			- 1	•

Health Financial Systems	LUTHERAN MUSCULOSKE	LETAL CENTER	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0168	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/30/2024 1: 3	8 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems LUTHERAN MUSCULOS	SKELETAL CENTER	In Lie	u of Form CMS-2	552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der CCN: 15-0168	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prep 5/30/2024 1:38	
	Title XVIII	Hospi tal	PPS	
	Inpatient Part A	Par	t B	

					5/30/2024 1: 38	8 pm
			XVIII	Hospi tal	PPS	
		Inpati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		6, 275, 329		8, 243, 797	1.00
2.00	Interim payments payable on individual bills, either			1	o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3.04
3.05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		6, 275, 329	1	8, 243, 797	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T	T	1		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider		1			F 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describber to Describe		0		0	5. 03
F F0	Provi der to Program	I	1	ı		
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (cum of lines 5 01 5 40 minus cum of lines		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		314		17, 356	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		6, 275, 643		8, 261, 153	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER In Lieu of Fo				u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0168 Period: From 01/01/2023				1
	To 12/31/2023				
				5/30/2024 1:3	38 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00 Medicare days (see instructions)					2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4. 00	Total inpatient days (see instructions)				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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HII technology	Wkst. S-2, Pt. I		7.00
0.00	line 168				0.00
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
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		T		1 20 00
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)	li 21) (itti-	>		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and 1	iine 31) (see instructio	ns)		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	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 1:38 pm
	Ti +Lo VIV	Uocni tal	Cost

			0 12/31/2023	5/30/2024 1: 3	8 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		629, 377		1.00
2.00	Medical and other services			276, 453	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		629, 377	276, 453	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		629, 377	276, 453	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		163, 372		8. 00
9.00	Ancillary service charges		2, 075, 912	3, 230, 392	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0 000 004	0 000 000	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 239, 284	3, 230, 392	12.00
12 00	CUSTOMARY CHARGES	r condides on a charge	O	0	12.00
13. 00	Amount actually collected from patients liable for payment fo	r services on a charge	U	Ü	13.00
14. 00	basis Amounts that would have been realized from patients liable fo	r navment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with		o o	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 9413. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		2, 239, 284	3, 230, 392	16.00
17. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	1, 609, 907	2, 953, 939	17.00
17.00	line 4) (see instructions)	Ty TT TTHE TO EXCEEDES	1,007,707	2, 700, 707	17.00
18. 00	Excess of reasonable cost over customary charges (complete on	lvifline 4 exceeds line	0	0	18.00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line	16)	629, 377	276, 453	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		629, 377	276, 453	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	`	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	629, 377	276, 453	
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34. 00 35. 00
35. 00 36. 00	Utilization review	4 33)	629, 377	274 452	
37. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an ZERO OUT SETTLEMENT	u 33)	-629, 377	276, 453 -276, 453	
38. 00	Subtotal (line 36 ± line 37)		-024, 377	-270, 453	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)			U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41. 00	Interim payments			0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	43.00
50	chapter 1, §115.2			Ü	
			. '		•

Health Financial Systems LUTHERAN MUSCULOSKELETAL CENTER I		In Lie	In Lieu of Form CMS-2552-10		
				Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep	pared:
				5/30/2024 1: 38	3 pm
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2,	or sum of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (s	see instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0. 00	5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00 Time value of money for capital related expenses (see instructions)					7.00

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

oni y)				1270172020	5/30/2024 1: 3	8 pm
		General Fund	Specific	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1				
1.00	Cash on hand in banks	-763, 463	1	0	0	1.00
2.00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4. 00	Accounts receivable	48, 098, 765	_	0	0	
5. 00	Other recei vabl e	0	Ö	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-4, 449, 131	0	0	0	
7.00	Inventory	3, 353, 192		0	0	
8. 00	Prepai d expenses	451, 640	1	0	0	
9. 00 10. 00	Other current assets Due from other funds	55, 153		0	0	
11. 00	Total current assets (sum of lines 1-10)	46, 746, 156	0	0	0	11.00
11.00	FIXED ASSETS	1 40, 740, 150	1 0	<u> </u>	<u> </u>	11.00
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	26, 765	0	0	0	13.00
14.00	Accumulated depreciation	-20, 699		0	0	
15.00	Bui I di ngs	133, 702		0	0	15. 00
16.00	Accumulated depreciation	-25, 746		0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	4, 789, 629		0	0	17. 00 18. 00
19.00	Fixed equipment	-2, 179, 503 2, 574, 655	1	0	0	19.00
20.00	Accumulated depreciation	-862, 560	1	0	0	20.00
21. 00	Automobiles and trucks	28, 303	1	0	0	21.00
22.00	Accumulated depreciation	-28, 303	·	0	0	22.00
23.00	Maj or movable equipment	21, 389, 392	0	0	0	23.00
24.00	Accumulated depreciation	-13, 088, 803	1	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	4, 069, 553		0	0	25. 00
26.00	Accumulated depreciation	-3, 001, 254	0	0	0	26.00
27. 00 28. 00	HIT designated Assets	0	0	0	0	27. 00 28. 00
29. 00	Accumulated depreciation Minor equipment-nondepreciable			0	0	
30.00	Total fixed assets (sum of lines 12-29)	13, 805, 131		0		
00.00	OTHER ASSETS	10,000,101	<u> </u>			00.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	24, 194, 519 24, 194, 519		0	0	34. 00 35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	84, 745, 806	1	0	0	36.00
00.00	CURRENT LIABILITIES	01,710,000	<u> </u>	<u> </u>	<u> </u>	00.00
37.00	Accounts payable	6, 521, 060	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 975, 009	0	0	0	38.00
39. 00	Payroll taxes payable	233, 233	0	0	0	39.00
40.00	Notes and loans payable (short term)	1, 841, 314	0	0	0	40.00
41.00	Deferred income Accelerated payments	0	0	U	0	41. 00 42. 00
42. 00 43. 00	Due to other funds	-473, 536, 099	0	0	0	
44. 00	Other current liabilities	760, 843	1	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	-461, 204, 640	1	0		
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable	21, 407, 061		0	0	
48. 00	Unsecured Loans	0	0	0	0	48.00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	54, 569, 553 75, 976, 614		0	0	49. 00 50. 00
51.00	Total liabilities (sum of lines 45 and 50)	-385, 228, 026		0	0	
01.00	CAPITAL ACCOUNTS	000, 220, 020	<u> </u>	<u> </u>		01.00
52.00	General fund balance	469, 973, 832				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted	ļ		0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57.00 58.00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	469, 973, 832	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	84, 745, 806	1	0	0	60.00
	59)					

Provider CCN: 15-0168

| Peri od: | Worksheet G-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					To	o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
		General	Fund	Speci al	Pu	rpose Fund	Endowment	
							Fund	
		4 00	0.00	2.00		4.00	F 00	
1 00	Fund balances at beginning of period	1. 00	2. 00 419, 845, 081	3.00		4. 00	5. 00	1.00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)		50, 128, 751			U		2.00
3. 00	Total (sum of line 1 and line 2)		469, 973, 832			0		3.00
4. 00	Additions (credit adjustments) (specify)	0	407, 773, 032		0	O	0	4.00
5. 00	Constant and astimonites, (speeding)	o			0		Ö	5. 00
6.00		0			0		0	6.00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9. 00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		469, 973, 832		_	0		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0		0	12. 00 13. 00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16.00
17. 00		o			0		Ö	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		469, 973, 832			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		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		0			3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6. 00			0					6.00
7. 00			0					7.00
8. 00			0					8.00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15.00			0					15.00
16. 00 17. 00			0					16. 00 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	o			0			19.00
	sheet (line 11 minus line 18)	ا			_			
	·	,						

| Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & II | To | 12/31/2023 | Date/Time | Prepared: Health Financial Systems LUTH STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0168

		Т	o 12/31/2023	Date/Time Pre 5/30/2024 1:3	
	Cost Center Description	I npati ent	Outpati ent	Total	<u>Б.</u>
		1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	14, 178, 614		14, 178, 614	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	349, 657		349, 657	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)	14, 528, 271		14, 528, 271	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	0		0	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT	0		0	11. 01
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT	0		0	14.00
	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16. 00
17. 00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	14, 528, 271		14, 528, 271	17. 00
18. 00	Ancillary services	309, 013, 419	775 571 020	1, 084, 584, 439	18.00
19. 00	Outpatient services	309, 013, 419	1, 190, 953		
	RURAL HEALTH CLINIC	321,047			20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			_	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	o o	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 to Wkst.	. 323, 862, 737	776, 761, 973	1, 100, 624, 710	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		146, 240, 479		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32. 00		0			32.00
33.00		0			33.00
34.00		0			34.00
35. 00	T-1-1 - 11'1' (6 1' 20 25)	0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39. 00 40. 00		0			39. 00 40. 00
40.00					40.00
41.00	Total deductions (sum of lines 37-41)		_		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	146, 240, 479		42.00
73.00	to Wkst. G-3, line 4)		170, 240, 477		75.00
	100	1	l .	ı	ı

Heal th	Financial Systems LUTHERAN MUSCU	LOSKELETAL CENTER	Inlie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0168	Peri od:	Worksheet G-3	1002 10
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/30/2024 1:3	
				07 007 202 1 1. 0	О ріп
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3	, line 28)		1, 100, 624, 710	1.00
2.00	Less contractual allowances and discounts on patients' a	ccounts		904, 582, 318	2.00
3.00	Net patient revenues (line 1 minus line 2)			196, 042, 392	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II,			146, 240, 479	
5.00	Net income from service to patients (line 3 minus line 4	.)		49, 801, 913	5.00
	OTHER I NCOME				
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 communic	ation services		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
	3 1			0	15.00
	Revenue from sale of medical and surgical supplies to ot	her than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
24.00	OTHER (SPECIFY)			326, 838	
	COVI D-19 PHE Funding			0	24.50
	Total other income (sum of lines 6-24)			326, 838	
	Total (line 5 plus line 25)			50, 128, 751	26.00
				0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29.00	Net income (or loss) for the period (line 26 minus line	28)		50, 128, 751	29.00

111-	Financial Customs	FLETAL CENTER	1 = 1 : =	£ F CMC /	DEED 40
	Financial Systems LUTHERAN MUSCULOSKE ATION OF CAPITAL PAYMENT	Provider CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet L	2552-10
			From 01/01/2023 To 12/31/2023	Parts I-III	nared.
			10 12/31/2023	5/30/2024 1: 3	
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			485, 068	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			5, 944	2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see ins	tructions)	10. 23	3.00
4. 00 5. 00	Number of interns & residents (see instructions)			0. 00 0. 00	4. 00 5. 00
6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the	o sum of lines 1 and 1 0	1 columns 1 and	0.00	6.00
0.00	1.01) (see instructions)	e sum of filles fallu 1.0	i, corumns rand	0	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0. 00	8.00
9. 00	Sum of lines 7 and 8	4611 6113)		0.00	
10.00	Allowable disproportionate share percentage (see instructions	s)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)	491, 012	12.00		
	DART II DAVMENT UNDER REACONARIE COCT			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2.00
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00 5. 00
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	netructione)		0 0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary		v line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	y crrcumstances (rine 2	X TITIE 0)	0	8.00
9. 00	Current year capital payments (from Part I, line 12, as appli	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over (Worksheet L. Part III, line 14)	capital payment (from pr	ior year	0	11. 00
12.00	Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus li	ne 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter	0	13.00		
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the	following period	0	14. 00
15.00	,	structi ons)		0	15. 00
16. 00				0	16. 00
17. 00	Current year exception offset amount (see instructions)			0	17. 00