Health Financial Systems LUTHERAN MUSCU	LOSKELETAL CENTER	In Lie	u of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b))			
payments made since the beginning of the cost reporting period	being deemed overpayments (	(42 USC 1395g).	OMB NO. 0938-0050
			EXPI RES 09-30-2025
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICA	FLON Provider CCN: 15-0168	Period: From 01/01/2022	Worksheet S Parts I-III
AND SETTLEMENT SUMMARY		To 12/31/2022	
			5/31/2023 9:13 am
PART I – COST REPORT STATUS			
Provider 1. [X] Electronically prepared cost report		Date: 5/31/20	23 Time: 9:13 am
use only 2. [ ] Manually prepared cost report			
3.[ 0 ] f this is an amended report enter the nu 4.[ F ]Medicare Utilization. Enter "F" for full,	"ber of times the provider	resubmitted this co	ost report
Contractor 5. [1] Cost Report Status 6. Date Received:		). NPR Date:	
use only (1) As Submitted 7. Contractor No.		. Contractor's Vendo	or Code: 4
(2) Settled without Audit 8. [ N ] Initial Repo	rt for this Provider CCN 12	2. [ 0 ]If line 5, cc	olumn 1 is 4: Enter
(3) Settled with Audit 9. [N] Final Report	for this Provider CCN		nes reopened = 0-9.
(4) Reopened			
(5) Amended			
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINIS	TRATOR OR PROVIDER(S)		
MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED		PUNISHABLE BY CRIM	
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LA			
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY			
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRAT	OR OF PROVIDER(S)		
I HEREBY CERTIFY that I have read the above certificati	on statement and that I hav	e examined the acco	ompanyi ng
electronically filed or manually submitted cost report			
Statement of Revenue and Expenses prepared by LUTHERAN	MUSCULOSKELETAL CENTER ( 15	5-0168 ) for the cos	st reporting
period beginning 01/01/2022 and ending 12/31/2022 and t			
statement are true, correct, complete and prepared from			
applicable instructions, except as noted. I further cer			
regarding the provision of health care services, and th	at the services identified	in this cost report	t were
provided in compliance with such laws and regulations.			

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRA	ATOR CHECKBOX		
	1	2	SI GNATURE 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	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	3, 996	18, 327	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	3, 996		0		200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

	THE AND HOST THE HEAETH GARE COMPLEX I	DENTIFICATION DATA	Provic	ler CCN	l: 15-016		Period: From 01/01/		Workshe Part I	et S-2	2
							o 12/31/	2022	Date/Ti 5/31/20		
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~~	Hospital and Hospital Health Care Co		1								1
00 00	Street: 7952 W. JEFFERSON BLVD City: FORT WAYNE	PO Box: State: IN	Zip Cod	e <sup>.</sup> 4680	)4	County	<i>.</i>				1.
		Component Name	CCN	CBS		vider	Date	Payme	nt Syst	em (P,	
			Number	Numb	er Ty	ype	Certified		0, or	1 '	4
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00	Subprovider - IPF	MUSCULOSKELETAL CENTER									4.
00	Subprovider - IRF										5.
00	Subprovider - (Other)										6.
00	Swing Beds - SNF										7.
00	Swing Beds - NF										8.
00 00	Hospital-Based SNF Hospital-Based NF										9.
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							1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/20	022	12/31/	2022	20.
00							4				21.
					1.0	00	2.00		3.0	00	
00	Inpatient PPS Information Does this facility qualify and is it	currently, receiving nay	ments for	-	N						22.
. 00	di sproporti onate share hospi tal adju										22.
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02	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Des this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Dees this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	r yes or "N" for no. Ps, including supplement column 1, "Y" for yes or g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 column 1, "Y" for yes or	andment al UCPs, or "N" for to Octobion of th o be er in col porting "N" for ober 1. ourban to stical ar "N" for r "N" for cost uctions) 9 beds (a 1. Ente tical are "N" for ourban to tical are "N" for tical are "N" for ourban to tical are "N" for stical are "N" for ourban to tical are stical are	- no per ne umn no, peas no er bas no er bas no er	N		N		Ν		22
02	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	r yes or "N" for no. Ps, including supplement column 1, "Y" for yes or g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 column 1, "Y" for yes or	andment al UCPs, or "N" for to Octobion of th o be er in col porting "N" for ober 1. ourban to stical ar "N" for r "N" for cost uctions) 9 beds (a 1. Ente tical are "N" for ourban to tical are "N" for tical are "N" for ourban to tical are "N" for stical are "N" for ourban to tical are stical are	- no per ne umn no, peas no er bas no er bas no er	N		N		Ν		22.
	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	r yes or "N" for no. Ps, including supplement column 1, "Y" for yes o g period occurring prior r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	endment al UCPs, or "N" for to Octobi ion of th be er in col porting "N" for ourban to stical ar "N" for r r 1. Ente e cost "Uctions) '9 beds (a cost ical area "N" for tr 1. Ente e cost "N" for r 1. Ente e cost (a) "Y" for er 1. Ente e cost (a) "Y" for (b) obs (a) "Y" for (c) obs (c) ob	- no per ne umn no, peas to pr eas pr p eas pr p eas pr p eas pr p eas pr p eas	N		N		Ν		22.
02	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Des this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	r yes or "N" for no. Ps, including supplement column 1, "Y" for yes or g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2. 105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2. 105)? Enter in column dic at days on lines 24 of admission, 2 if censu	endment al UCPs, or "N" for to Octobi ion of th o be er in col porting "N" for ober 1. ourban to stical ar "N" for r ar 1. Ente e cost ourban to tical are "N" for ourban to tical are "N" for and/or 25 s days, ourban tical are tical are s days, ourban and/or 25 s days, ourban tical are tical are	- no ber ne umn no, beas no er bas ro eas no er bas ro bas ro bas ro bas ro bas ro bas ro bas ro bas ro bas ro ro ro ro ro ro ro ro ro ro ro ro ro	N		N		Ν		22. 22. 22. 22. 22. 22.
02	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 201? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital contain at least counted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	r yes or "N" for no. Ps, including supplement column 1, "Y" for yes or g period occurring prior "N" for no for the port r after October 1. (see requires a final UCP to ? (see instructions) Ent e portion of the cost re column 2, "Y" for yes or g period on or after Oct ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 45 2.105)? Enter in column dic nectober 1. (see instr 100 but not more than 45 2.105)? Enter in columr dicaid days on lines 24 of admission, 2 if censu	endment al UCPs, or "N" for to Octob ion of th o be er in col porting "N" for ourban to stical ar "N" for r tr 1. Ente te cost uctions) 9 beds (a 3, "Y" for ourban to tical are "N" for any f	- no ber ne umn no, beas no er bas ro eas no er bas ro bas ro bas ro bas ro bas ro bas ro bas ro bas ro bas ro ro ro ro ro ro ro ro ro ro ro ro ro	N		N		Ν		22

alth Financial Systems LUTHERAN M SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	AUSCULOSKELI	Provider CC		Perio	od:		u of For Worksh		
				From To		1/2022 1/2022	Part I Date/T 5/31/2		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Sta Medic eligi unpa	te aid ble	Medica HMO da	ys Mee	ither di cai d days	
.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.0	0	5.00	0	6.00	) 24.0
<ul> <li>in this provide is an IPPs hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible but unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>16 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state</li> </ul>					0		0		25. (
Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
				Ur	ban/R 1. (		Date of 2.		
00 Enter your standard geographic classification (not w		at the beg	jinning of t	the		1			26.0
<ul> <li>cost reporting period. Enter "1" for urban or "2" fo</li> <li>Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif</li> <li>If this is a sole community hospital (SCH), enter th</li> </ul>	age) status r "2" for r ication in	ural. If ap column 2.	pl i cabl e,			1			27.0
effect in the cost reporting period.					Begi nr	ni na:	Endi	na:	
00 Fater called basics and adias datas of COUs	tatua Cuba		2/ 6		1. C		2.		2(
00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat	es.	·							36.
.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	r of period	ls MDH statu	s		0			37.
.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)									37.
.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.									38.
					Y/ 1. (		Y/ 2.	<u>′N</u> 00	-
.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), or the mileage ii)? Enter	(iii)? Ent requiremer in column 2	er in colur nts in 2 "Y" for ye	nn es		N N			39.
.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r"Y" for y			N		٩	1	40.
						V 1.00	XVIII 2.00	XIX 3.00	
Prospective Payment System (PPS)-Capital									
<ul> <li>00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)</li> <li>00 Is this facility eligible for additional payment exc</li> </ul>	eption for	extraordi na	ary circumst	tances		N N	N N	N N	45. 46.
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. .00 Is this a new hospital under 42 CFR §412.300(b) PPS					0	N	N	N	47.
.00 Is the facility electing full federal capital paymen Teaching Hospitals						N	N	N	48.
<ul> <li>100 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2</li> <li>100 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which</li> </ul>	"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir er 27, 2020 residents	or <sup>"</sup> N <sup>"</sup> for under 42 C "Y", or if prior year ect GME pay , if line 5 in approved	no in colu CFR 413.78(k this hospin or penultir yment reduct 56, column d GME progra	umn 1. b)(2), tal was nate ye tion? E l, is y ams tra	For see ar, inter	N			56.
at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not compl. 00 If line 56 is yes, did this facility elect cost reim	cost report e Worksheet applicable R 413.77(e on duty, i ete column	ing period? E-4. If cc . For cost )(1)(iv) ar f the respo 2, and comp	P Enter "Y' olumn 2 is ' reporting p nd (v), rega onse to line olete Workst	'fory 'N", periods ardless e56 is neetE-	of "Y"				58.

		TA	Provider CC	Fi To		Date/Time 5/31/2023	9:1	pared:
					V 1.00		(I X 00	
9.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	lete Wkst. D-2,	Pt. I.	N	0 2.00 3	. 00	59.0
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Thro Qual i fi cat Cri teri on	tion	
				1.00	2.00	3.00		
0.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHE	see If column 1	N				60. 0
		Y/N	IME	Direct GME	IME	Direct G	ME	
		1.00	2.00	3.00	4.00	5.00		
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00		0. 00	61.0
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61. C
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.0
1.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61. (
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary							61. (
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Dra	agreem Nome	Drognom Code	Unuci abtod LMC		od	61. (
		PI	ogram Name			Direct GME Count		
1. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents		1.00	2.00	3.00	4.00	0. 00	61. 1
	For each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.							
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	)	0.00	61.2
						1.00		
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital	trai neo			od for which	1	0. 00	62. 0
2. 01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi			your hospital		0. 00	62. C

	i Financial Systems TAL AND HOSPITAL HEALTH CARE COMPI		MUSCULOSKELETAL CENTE ATA Provider C	CN: 15-0168 F	Period:	Worksheet S-2	<u>2552-1</u> ?
					rom 01/01/2022 o 12/31/2022		epared: 3 am
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	1
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J			-This base year	'is your cost r	reporting	
. 00		yes, or your facili ber of unweighted non tations occurring in number of unweighter ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 0	0 0.00	0. 000000	64.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
		5	5	FTĔs	FTEsin	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			-
		1.00	2.00	3.00	4.00	5.00	
. 00	Enter in column 1, if line 63 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. 0	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2)) 3.00	-
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settinç	gsEffective f	or cost reporti	ng periods	
. 00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0. 0	0 0.00	0. 000000	) 66.0
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
7.00	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			0.0	D O. OC	0. 000000	0 67.0

Heal th	Financial Systems LUTHERAN MUSCULOSKELETAL CENTER		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		eriod:	Worksheet S-2	2
			rom 01/01/2022 o 12/31/2022		pared:
				5/31/2023 9:1	3 am
				1.00	
(0,00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490			N	40.00
68.00	For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina			N	68.00
	(August 10, 2022)?				
			1.0	0 2.00 3.00	-
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta Enter "Y" for yes or "N" for no.	nin an IPF subp	provider? N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teachir	ng program in 1	the most	0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for ye				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye				
	Column 3: If column 2 is Y, indicate which program year began during this				
	(see instructions) Inpatient Rehabilitation Facility PPS				-
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ontain an IRF	N		75.00
74 00	subprovider? Enter "Y" for yes and "N" for no.	a program in t	the meet	0	76.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teachir recent cost reporting period ending on or before November 15, 2004? Enter				76.00
	no. Column 2: Did this facility train residents in a new teaching program	in accordance	with 42		
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see				
			I		
	Long Term Care Hospital PPS			1.00	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r	10.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the c	cost reporting	period? Enter	N	81.00
	"Y" for yes and "N" for no. TEFRA Providers				
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	42 CFR Section	1		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified u	Inder section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Approved for	Number of	
			Permanent	Approved	
			Adjustment	Permanent Adjustments	
			(Y/N) 1.00	2.00	-
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF			0	88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions)	of. 2 and line			
	Column 2: Enter the number of approved permanent adjustments.				
		Wkst. A Line No.	Effective Dat	e Approved Permanent	
		110.		Adjustment	
				Amount Per Discharge	
		1.00	2.00	3.00	-
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00			89.00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period				
	beginning date) for the permanent adjustment to the TEFRA target amount				
	per discharge. Column 3: Enter the amount of the approved permanent adjustment to the				
	TEFRA target amount per discharge.				
			V 1.00	XI X 2.00	-
	Title V and XIX Services		1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Er yes or "N" for no in the applicable column.	nter "Y" for	N	Y	90.00
91.00	is this hospital reimbursed for title V and/or XIX through the cost report	either in	N	Y	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.				
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.	un)? (see		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and	I XIX? Enter	N	N	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	in the	N	N	94.00
	applicable column.				
	If line 94 is "Y", enter the reduction percentage in the applicable column Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no		0.00 N	0.00 N	95.00 96.00
70.00	applicable column.			IN	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column	1.	0.00	0.00	97.00

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	i i ovi aci o		eri od:	Worksheet S-	-2
				rom 01/01/2022 o 12/31/2022		repared
				V	5/31/2023 9:	
				1.00	XI X 2.00	_
98.00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			N	Y	98. C
98. 01	Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			N	Y	98. C
8. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			N	Y	98. C
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N	Ν	98.0
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98.0
98. 05	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.			N	Y	98.0
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.		N	Y	98. C	
	Rural Providers			N		105 0
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of payment	N		105. 0 106. 0
107.00	Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	1. (see ins you train I&R	structions) As in an			107. 0
108.00	Enter "Y" for yes or "N" for no in column 2. (see instructi Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ons)		Ν		108. (
	-	Physi cal 1.00	Occupational	Speech	Respi ratory	/
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u> </u>	2.00	3.00	4.00	109. 0
					1.00	-
110.00	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. It	° yes,	N	110. (
				1.00		_
11 00	If this facility qualifies as a CAH, did it participate in t	he Frontier C	Community	1.00 N	2.00	111. (
	Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par	st reporting	period? Enter			
	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ticipating in				
	Enter all that apply: "A" for Ambulance services; "B" for ad	ticipating in	; and/or "C"	2.00	3.00	_
112.00	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea	ticipating in ditional beds th Model porting lumn 1 is ating in the		2.00	3.00	112. (
	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	ticipating in ditional beds th Model porting lumn 1 is ating in the sed and Rural	; and/or "C"	2.00	3.00	
13.00	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider	ticipating in ditional beds th Model porting lumn 1 is ating in the sed and Rural cost "N" for no , or E only) 3" percent includes	; and/or "C"	2.00	3.00	113. (
113. OC 115. OC	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y"	ticipating in ditional beds th Model porting lumn 1 is ating in the sed and Rural cost "N" for no , or E only) 3" percent includes s) based on	;; and/or "C"	2.00	3.00	112. C 113. C 0 115. C 116. C
113. OC 115. OC 116. OC	Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services. Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care ( psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	ticipating in ditional beds th Model porting lumn 1 is ating in the sed and Rural cost "N" for no , or E only) 3" percent includes s) based on for yes or	;; and/or "C"	2.00	3.00	113. ( 0115. (

Ith Financial Systems LUTH PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	ATA Provider CCN:	1	Period: From 01/01/2022 To 12/31/2022	Worksheet S Part I	repared
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
8.01 List amounts of malpractice premiums and paid I	5:	7, 39			0 118. (
			1.00	2.00	
8.02 Are malpractice premiums and paid losses report Administrative and General? If yes, submit sup			N	2.00	118.
and amounts contained therein. 2.00D0 NOT USE THIS LINE					119.
0.00 Is this a SCH or EACH that qualifies for the Ou §3121 and applicable amendments? (see instructi "N" for no. Is this a rural hospital with < 100 Hold Harmless provision in ACA §3121 and applic Enter in column 2, "Y" for yes or "N" for no.	Enter in column 1, "Y" f s that qualifies for the	for yes or Outpatient	N	N	120.
.00 Did this facility incur and report costs for hi patients? Enter "Y" for yes or "N" for no.	ost implantable devices o	charged to	Y		121.
2.00 Does the cost report contain healthcare related Act?Enter "Y" for yes or "N" for no in column 1	column 1 is "Y", enter i		Ν		122.
the Worksheet A line number where these taxes a 3.00 Did the facility and/or its subproviders (if ap services, e.g., legal, accounting, tax preparat management/consulting services, from an unrelat for yes or "N" for no.	able) purchase professior bookkeeping, payroll, ar	nd/or			123.
If column 1 is "Y", were the majority of the ex professional services expenses, for services pu located in a CBSA outside of the main hospital "N" for no.	sed from unrelated organi	zati ons			
Certified Transplant Center Information 5.00Does this facility operate a Medicare-certified	nsplant center? Enter "Y"	' for yes	N		125.
and "N" for no. If yes, enter certification dat 0.00 If this is a Medicare-certified kidney transpla	(mm/dd/yyyy) below.	3	<b>_</b>		126.
in column 1 and termination date, if applicable 2.00 If this is a Medicare-certified heart transplan	column 2.				127.
in column 1 and termination date, if applicable 8.00 f this is a Medicare-certified liver transplan	column 2.				128.
in column 1 and termination date, if applicable 0.00 If this is a Medicare-certified lung transplant		ation date			129.
in column 1 and termination date, if applicable 0.00 If this is a Medicare-certified pancreas transp	program, enter the certi	fi cati on			130.
date in column 1 and termination date, if appli .00 f this is a Medicare-certified intestinal tran	nt program, enter the cer	rti fi cati on			131.
date in column 1 and termination date, if appli 2.00 If this is a Medicare-certified islet transplan in column 1 and termination date, if applicable	ogram, enter the certific	cation date			132
0.00Removed and reserved 0.00If this is a hospital-based organ procurement o		0P0 number			133. 134.
in column 1 and termination date, if applicable All Providers	column 2.				_
0.00 Are there any related organization or home offichapter 10? Enter "Y" for yes or "N" for no in are claimed, enter in column 2 the home office	nn 1. If yes, and home of	ffice costs	Y	HB1848	140.
1.00	2.00	h 142 tho n	3.00	of the	
If this facility is part of a chain organization home office and enter the home office contractor	me and contractor number.				
	Name: WI SCONSIN PHYSICIA SERVICES	N Contracto	or's Number: 5228	30	141.
2.00 Street: 4000 MERIDIAN BLVD PO Box: 3.00 City: FRANKLIN State:	TN	Zip Code:	3706	57	142. 143.
		121 p 0000.	3700		
.00 Are provider based physicians' costs included i	ksheet A?			1.00 Y	144.
.00  f costs for renal services are claimed on Wkst inpatient services only? Enter "Y" for yes or "			1.00	2.00	145
no, does the dialysis facility include Medicare period? Enter "Y" for yes or "N" for no in col	ization for this cost re	eporting			
5.00 Has the cost allocation methodology changed fro Enter "Y" for yes or "N" for no in column 1. (S	e previously filed cost r		N		146.

HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0168	Perio From To	od: 01/01/2022 12/31/2022		epared:
		I					_
147.00Was there a change in the statisti	cal basis2 Entor "V" for y	os or "N" for	20			1.00 N	147.00
148.00Was there a change in the order of						N	148.00
149.00Was there a change to the simplifi				or no.		N	149.00
		Part A	Part B		Title V	Title XIX	
		1.00	2.00		3.00	4.00	1
Does this facility contain a prov or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		N	N	155.00
56.00 Subprovider - IPF		Ν	N		N	N	156.00
57.00 Subprovi der – IRF		Ν	N		N	N	157.00
58. 00 SUBPROVI DER							158.00
59. 00 SNF		N	N		N	N	159.00
60. 00 HOME HEALTH AGENCY		N	N		N	N	160.00
61. 00 CMHC			N		N	N	161.00
61. 10 CORF			N		N	N	161.10
						1.00	-
Multicampus							
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	impus hospital that has one	e or more campu	ıses in dif	ferent	CBSAs?	N	165.00
	Name	County		Zip Cod		FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 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	0166.00
						1.00	-
Health Information Technology (HI	) incentive in the America	an Recovery and	Reinvestm	ent Act		1.00	
67.00 Is this provider a meaningful user						Y	167.00
68.00 If this provider is a CAH (line 10	05 is "Y") and is a meaning	gful user (lin∈		"), ent	er the		168.00
reasonable cost incurred for the l 68.01 If this provider is a CAH and is i			qualify f	or o ho	rdchin		168.0
exception under §413.70(a)(6)(ii)					i usii p		100.0
69.00 If this provider is a meaningful i	user (line 167 is "Y") and				enter the	9.9	9169.00
transition factor. (see instruction	ins)				Begi nni ng	Endi ng	
					1.00	2.00	1
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and ending c	date for the re	porti ng				170. 00
· · · · · · · · · · · · · · · · · · ·					1.00	2.00	-
71.00 If line 167 is "Y", does this prov	ider have any days for inc	tividuals enrol	led in		N		0171.0
"Y" for yes and "N" for no in colu 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt. mn 1. If column 1 is yes,	I, line 2, col	. 6? Enter				

)SPI T	Financial Systems LUTHERAN MUSCULOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-0168	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2022 To 12/31/2022	Date/Time Pr	
				Y/N	5/31/2023 9:	<u>13 am</u>
				1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTIONN	IAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	er all dates in 1	the	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
00	reporting period? If yes, enter the date of the change in c					1
			Y/N	Date	V/I	_
00	Has the provider terminated participation in the Medicare P	magnam2 lf	1.00 N	2.00	3.00	2.0
00	yes, enter in column 2 the date of termination and in column voluntary or "1" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	iffices, drug ler or its if the board	N			3.
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ilable in	N			4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
			1	Y/N 1.00	Legal Oper. 2.00	
~ ~	Approved Educational Activities			•		
00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	5	s the provide	r N N		6. 7.
00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	d and/or renew	Ũ	e N		8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	IS.				9.
). 00 1. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		10.
1.00	Teaching Program on Worksheet A? If yes, see instructions.		Ji oved	N	Y/N	11.
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	12. 13.
1.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	nce amounts wa	aived? If yes	see	Ν	14.
	Bed Complement					
. 00	Did total beds available change from the prior cost reporti		<u>yes, see ins</u> rt A		N N	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data	Y	05/16/2023	Y	OF /1/ /2022	16.
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	T	0371072023	T	05/16/2023	10.
. 00	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 in columns 2 and 4. (see instructions)	Ν		Ν		17.
. 00	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 cost report? If yes, see instructions.	Ν		N		18.
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

Health Financial Systems

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

Health Financial Systems LUTHERAN MUSCUL	LOSKELETAL CENTE	R	In Lie	In Lieu of Form CMS-						
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2022 To 12/31/2022							
				5/31/2023 9:						
	Descr	iption	Y/N	Y/N						
		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:			Ν	Ν	20.00					
	Y/N	Date	Y/N	Date						
	1.00	2.00	3.00	4.00						
21.00 Was the cost report prepared only using the provider's	N		N		21.00					
records? If yes, see instructions.										
				1.00	-					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS H	IOSPI TALS)								
Capital Related Cost										
22.00 Have assets been relifed for Medicare purposes? If yes, s	see instructions				22.00					
23.00 Have changes occurred in the Medicare depreciation expension reporting period? If yes, see instructions.		sals made duri	ng the cost		23.00					
24.00 Were new leases and/or amendments to existing leases enter	ered into during	this cost rep	orting period?		24.00					
If yes, see instructions 25.00  Have there been new capitalized leases entered into durin	ng the cost repor	ting period?	lfyes, see		25.00					
instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during	the cost reporti	na period? If	ves, see		26.00					
instructions.		0 1	5							
27.00 Has the provider's capitalization policy changed during t copy.	ne cost reportir	ig period? if	yes, sudmit		27.00					
28.00 Were new Loans, mortgage agreements or letters of credit										
period? If yes, see instructions.	period? If yes, see instructions.									
29.00 Did the provider have a funded depreciation account and/c treated as a funded depreciation account? If yes, see ins		ebt Service Re	serve Fund)		29.00					
30.00 Has existing debt been replaced prior to its scheduled ma		debt? If yes,	see		30.00					
31.00 Has debt been recalled before scheduled maturity without	issuance of new	debt? If yes,	see		31.00					
instructions. Purchased Services					_					
32.00 Have changes or new agreements occurred in patient care s arrangements with suppliers of services? If yes, see inst		ed through con	tractual		32.00					
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 a		ng to competit	ive bidding? If		33.00					
no, see instructions.					-					
Provi der-Based Physi ci ans	orrongement wit	the provider he	and physicians?							
34.00 Were services furnished at the provider facility under an If yes, see instructions.	i arrangement wit	in provider-ba	sed physicians?		34.00					
35.00 If line 34 is yes, were there new agreements or amended e	existina aareemer	nts with the p	rovi der-based		35.00					
physicians during the cost reporting period? If yes, see										
			Y/N	Date						
			1.00	2.00						
Home Office Costs										
36.00Were home office costs claimed on the cost report?37.00If line 36 is yes, has a home office cost statement been	prepared by the	home office?	Y Y		36.00 37.00					
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home of			Y	12/31/2021	38.00					
the provider? If yes, enter in column 2 the fiscal year e	end of the home o	offi ce.		12/ 51/ 2021						
39.00 If line 36 is yes, did the provider render services to ot see instructions.	her chain compor	nents? If yes,	N		39.00					
40.00 If line 36 is yes, did the provider render services to th instructions.	ne home office?	lf yes, see	Ν		40.00					
	1	00	2	00	_					
Cost Report Preparer Contact Information	1.	00	Ζ.	00						
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	CODY		OWENS		41.00					
respectively.										
42.00 Enter the employer/company name of the cost report preparer.	COMMUNI TY HEAL	IH SYSTEMS			42.00					
	615-465-2727		MI CHAEL_OWENS@	CHS. NET	43.00					
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-2727		MI CHAEL_OWENS@	CHS. NET	43.0					

Heal th	Financial Systems LUTHERAN	MUSCULOS	SKELETAL	CENTER		In Li€	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	I RE	Provi	der CCN:		Period:	Worksheet S-2		
						From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 5/31/2023 9:1	pared: <u>3 am</u>	
				3.00			-		
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/positi	on	MANAGER,	REVENUE	MANAGEMENT			41.00	
	held by the cost report preparer in columns 1, 2, ar	nd 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cost report							42.00	
	preparer.								
43.00	Enter the telephone number and email address of the	cost						43.00	
	report preparer in columns 1 and 2, respectively.								

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/31/2023 9:1	pared:
						I/P Days / 0/P	
						<u>Visits / Trips</u>	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	39	14, 23	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	37	14, 20	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		39	14, 23	. 00	0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
8.00 9.00	CORONARY CARE UNIT	31.00	0		0 0.00	0	
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	01.00	0		0.00	, v	12.00
13.00	NURSERY	43.00				0	•
14.00	Total (see instructions)		39	14, 23	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	•
20.00	NURSING FACILITY	45.00	0		0	0	20.00
21.00	OTHER LONG TERM CARE	46.00	0		0		21.00
22.00	HOME HEALTH AGENCY	101.00				0	
23.00	AMBULATORY SURGICAL CENTER (D. P. )	115.00			-		23.00
24.00 24.10	HOSPICE	116. 00 30. 00	0		0		24.00
24.10	HOSPICE (non-distinct part) CMHC - CMHC	30.00 99.00				0	24.10
25.00	CMHC - CMHC CMHC - CORF	99.00 99.10					25.00
26.00	RURAL HEALTH CLINIC	88.00					25.10
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	37.00	39				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges	20.00	_				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	I	0	0	34.00

HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-3 Part I Date/Time Pre	
					10 12/31/2022	5/31/2023 9:1	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
	PART I – STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	878	327	3, 823	3		1 1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 382	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	(	D		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0	(	D		6.00
7.00	Total Adults and Peds. (exclude observation	878	327	3, 823	3		7.00
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	0	0	(	D		8.00
9.00	CORONARY CARE UNIT	0	0	(	D		9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	(	D		10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T	0	0	(	D		11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	(	D		13.00
14.00	Total (see instructions)	878	327	3, 823	3 0.00	300.60	14.00
15.00	CAH visits	0	0		D		15.00
16.00	SUBPROVIDER - IPF	0	0	(	0.00	0.00	16.00
17.00	SUBPROVI DER – I RF	0	0	(	0.00	0.00	
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	o	0	(	0.00	0.00	19.00
20.00	NURSING FACILITY	-	0		0.00	0,00	
21.00	OTHER LONG TERM CARE		-	(	0.00	0.00	
22.00	HOME HEALTH AGENCY	0	0	(	0.00	0.00	
23.00	AMBULATORY SURGICAL CENTER (D. P. )		0		0.00	0,00	
24.00	HOSPICE	0	0	(	0.00	0.00	
24.10	HOSPICE (non-distinct part)	0	0		0.00	0.00	24.10
25.00	CMHC - CMHC	0	0		0.00	0.00	
25.10	CMHC - CORF	0	0		0.00	0.00	
26.00	RURAL HEALTH CLINIC	0	0		0.00	0.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	•
27.00	Total (sum of lines 14-26)	0	0	· · · · · · · · · · · · · · · · · · ·	0.00	300.60	
28.00	Observation Bed Days		0	1, 72		300.00	28.00
29.00	Ambul ance Trips	o	0	1,72	'		29.00
30.00	Employee discount days (see instruction)	0		(			30.00
31.00	Employee discount days (see fistraction)						31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32.00 32.01	Total ancillary labor & delivery room	U	0	(			32.00
JZ. UI	outpatient days (see instructions)			(			32.01
33.00	LTCH non-covered days	o					33.00
	LIGH HOH-COVELEG Gays	U			1		1 55.00
33.01	LTCH site neutral days and discharges	0					33.01

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/31/2023 9:1	pare
		Full Time		Dis	scharges		
	Component	Equi val ents	Title V	Title XVII	Title XIX	Total All	
	Component	Nonpaid Workers 11.00	12.00	13.00	14.00	Pati ents 15.00	
	PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		C	3	51 117	1, 495	1.
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			4	59 0		2.
00	HMO IPF Subprovider				0		3.
00	HMO IRF Subprovider				0		4.
00	Hospital Adults & Peds. Swing Bed SNF						5
00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 7.
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	0.00	C	3	51 117	1, 495	14
5.00	CAH visits						15
. 00	SUBPROVIDER - IPF	0.00	C		0 0	0	16
. 00	SUBPROVIDER - IRF	0.00	C		0 0	0	17
. 00	SUBPROVIDER						18
. 00	SKILLED NURSING FACILITY	0.00					19
. 00	NURSING FACILITY	0.00				_	20
. 00	OTHER LONG TERM CARE	0.00				0	
. 00	HOME HEALTH AGENCY	0.00					22
. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23
. 00	HOSPICE	0. 00					24
. 10	HOSPICE (non-distinct part) CMHC - CMHC	0.00					24
. 00	CMHC - CMHC CMHC - CORF	0.00					25
. 00	RURAL HEALTH CLINIC	0.00					20
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 25	Total (sum of lines 14-26)	0.00					20
. 00	Observation Bed Days	0.00					28
. 00	Ambul ance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days (see fisting the fi						31
. 00	Labor & delivery days (see instructions)						32
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32
. 00	LTCH non-covered days				0		33
3. 01	LTCH site neutral days and discharges				0		33
1.00	Temporary Expansion COVID-19 PHE Acute Care						34

PLL	AL WAGE INDEX INFORMATION			SKELETAL CENTER Provider CC	N: 15-0168	Period: From 01/01/2022 To 12/31/2022		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
0	Total salaries (see	200.00	23, 562, 295	5 0	23, 562, 29	5 625, 249. 00	37.68	1
0	instructions) Non abuaician anasthatist Dant					0 0 00	0.00	
0	Non-physician anesthetist Part A		C	0		0 0.00	0.00	2
0	Non-physician anesthetist Part		C	0 0		0.00	0. 00	3
0	B Physician-Part A -		(			0 0.00	0. 00	4
0	Administrative		C			0.00	0.00	
1	Physicians - Part A - Teaching		C	0 0		0 0.00		
0	Physician and Non		C	0 0		0 0.00	0.00	5
0	Physician-Part B Non-physician-Part B for		C	0		0.00	0.00	6
0	hospital -based RHC and FQHC					0,00	0.00	
	services	01.00					0.00	
0	Interns & residents (in an approved program)	21.00	(	0 0		0 0.00	0.00	
1	Contracted interns and		C	0 0		0.00	0.00	5
	residents (in an approved							
0	programs) Home office and/or related		ſ			0 0.00	0. 00	8
0	organization personnel		C			0.00	0.00	`
0	SNF	44.00	C	0 0		0 0.00		
00	Excluded area salaries (see instructions)		2, 639, 854	н О	2, 639, 85	4 103, 455. 00	25. 52	1(
	OTHER WAGES & RELATED COSTS	1		1 1				
00	Contract Labor: Direct Patient		1, 558, 974	l 0	1, 558, 97	4 18, 141. 00	85.94	11
00	Carte		41 (()		41 (7	( 02.00	F02.00	1.
00	Contract labor: Top level management and other		41, 666	0	41, 66	6 83.00	502.00	I∠
	management and administrative							
~~	services						0.00	1 1
00	Contract Labor: Physician-Part A - Administrative		(	0 0		0 0.00	0.00	
00	Home office and/or related		C	0 0		0.00	0.00	14
	organization salaries and							
01	wage-related costs Home office salaries		3, 129, 372		3, 129, 37	2 87, 150. 00	35. 91	1
02	Related organization salaries		0, 127, 072	1		0 0.00		
00	Home office: Physician Part A		C	0 0		0 0.00	0.00	1
00	- Administrative Home office and Contract		C	o o		0.00	0.00	1
00	Physicians Part A - Teaching		C C			0.00	0.00	
01	Home office Physicians Part A		C	0 0		0 0.00	0.00	10
02	- Teaching Home office contract		ſ	o o		0.00	0. 00	1
02	Physicians Part A - Teaching		C C			0.00	0.00	
	WAGE-RELATED COSTS	T		-1		-1		
00	Wage-related costs (core) (see instructions)		5, 482, 958	3 0	5, 482, 95	8		1
00	Wage-related costs (other)							18
	(see instructions)				0== 1			
00 00	Excluded areas Non-physician anesthetist Part		977, 816		977, 81	6		19
00	Non-physician anesthetist Part A		(					20
00	Non-physician anesthetist Part		C	0		0		2'
00	B Physician Part A -		r			0		22
00	Administrative		C	, 				
01	Physician Part A - Teaching		C	0		0		2
00	Physician Part B		(			0		2:
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		( r			0		24
	approved program)		· · · · ·			-		_``
50	Home office wage-related		821, 527	0	821, 52	7		2!
51	(core) Related organization		r			0		2!
JI	wage-related (core)		C	j l				23
52	Home office: Physician Part A		C	0		0		25
	- Administrative - wage-related (core)							1

Heal th	Financial Systems	LUT	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part II Date/Time Pre 5/31/2023 9:1	pared:
		Wkst. A Line Number		Reclassificati on of Salaries	Sal ari es	Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25. 53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0		0		25. 53
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00	16, 442		16, 44			
27.00	Administrative & General	5.00	5, 224, 587	-143, 965	5, 080, 62			
28.00	Administrative & General under contract (see inst.)		0	0		0 0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	89, 917	0	89, 91	7 2, 368.00	37.97	30.00
31.00	Laundry & Linen Service	8.00	0	0		0.00	0.00	31.00
32.00	Housekeepi ng	9.00	2,069	0	2,06	9 60.00	34.48	32.00
33.00	Housekeeping under contract (see instructions)		574, 026	0	574, 02	6 35, 324. 69	16. 25	33.00
34.00	Dietary	10.00	0	0		0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		83, 663	0	83, 66	3 3, 457. 00	24. 20	35.00
36.00	Cafeteria	11.00	0	0		0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	714, 956	143, 965	858, 92	1 19, 405. 00	44.26	38.00
39.00	Central Services and Supply	14.00	675, 471	0	675, 47	1 22, 883.00	29. 52	39.00
40.00	Pharmacy	15.00	268, 040	0	268, 04			
41.00	Medi cal Records & Medi cal Records Library	16.00	25, 675		25, 67			41.00
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems	LU <sup>-</sup>	THERAN MUSCULO	SKELETAL CENTER	R	In Lie	eu of Form CMS-2	2552-10
HOSPI 7	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2022 To 12/31/2022		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		24, 219, 984	0	24, 219, 98	4 664, 030. 69	36.47	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 639, 854	0	2, 639, 85	4 103, 455. 00	25.52	2.00
3.00	Subtotal salaries (line 1		21, 580, 130	0	21, 580, 13	0 560, 575. 69	38. 50	3.00
4.00	minus line 2) Subtotal other wages & related costs (see inst.)		4, 730, 012	0	4, 730, 01	2 105, 374. 00	44. 89	4.00
5.00	Subtotal wage-related costs (see inst.)		6, 304, 485	0	6, 304, 48	5 0.00	29. 21	5.00
6.00	Total (sum of lines 3 thru 5)		32, 614, 627	0	32, 614, 62	7 665, 949. 69	48.97	6.00
7.00	Total overhead cost (see		7, 674, 846	0	7, 674, 84	6 221, 737. 69	34.61	7.00
	instructions)							

	Financial Systems LUTHERAN MUSCULOSK				u of Form CMS-		
SPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0	1	Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre	epare	
					5/31/2023 9:1	3 am	
					Amount		
					Reported 1.00		
	PART IV - WAGE RELATED COSTS				1.00		
	Part A - Core List					-	
	RETIREMENT COST					-	
00	401K Employer Contributions				493, 018	1 1.	
00	Tax Sheltered Annuity (TSA) Employer Contribution				0		
00	Nonqualified Defined Benefit Plan Cost (see instructions)						
00							
-	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				0	4.	
00	401K/TSA Plan Administration fees				0	5.	
00	Legal /Accounting/Management Fees-Pension Plan				0	6	
00	Employee Managed Care Program Administration Fees				0	7	
	HEALTH AND INSURANCE COST						
00	Health Insurance (Purchased or Self Funded)				0	8	
01	Health Insurance (Self Funded without a Third Party Administ	rator)			0	8	
)2	Health Insurance (Self Funded with a Third Party Administrate	or)			4, 185, 622	8	
23	Health Insurance (Purchased)				0	-	
00	Prescription Drug Plan				0	1	
. 00	Dental, Hearing and Vision Plan					10	
00	Life Insurance (If employee is owner or beneficiary)				13, 811		
. 00	Accident Insurance (If employee is owner or beneficiary)				-	12	
00	Disability Insurance (If employee is owner or beneficiary)				3, 528		
. 00	Long-Term Care Insurance (If employee is owner or beneficiary	y)			-	14	
00	'Workers' Compensation Insurance				105, 985		
. 00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual re	equi red	by FASB 106.	0	16	
	Noncumulative portion) TAXES					-	
00	FICA-Employers Portion Only				1, 306, 859	1 17	
	Medicare Taxes - Employers Portion Only				305, 636		
00	Unemployment Insurance					19	
	State or Federal Unemployment Taxes				46, 383		
00	OTHER				40, 303	20	
00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on Lines 1	through	1 4 above (see	0	21	
50	instructions))				Ĭ	1-'	
00	Day Care Cost and Allowances				0	22	
	Tuition Reimbursement				0		
. 00	Total Wage Related cost (Sum of lines 1 -23)				6, 460, 772	24.	
	Part B - Other than Core Related Cost						
00	OTHER WAGE RELATED COSTS (SPECIFY)					25.	

Heal th	Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	In Lieu of Form CMS-2552-10				
HOSPI	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0168	Peri od:	Worksheet S-3				
			From 01/01/2022 To 12/31/2022		narad			
			10 12/31/2022	5/31/2023 9:1				
	Cost Center Description		Contract Labor					
	·		1.00	2.00				
	PART V - Contract Labor and Benefit Cost							
	Hospital and Hospital-Based Component Ide	entification:						
1.00	Total facility's contract labor and bene	fit cost	1, 558, 974		1.00			
2.00	Hospi tal		1, 558, 974	6, 460, 772	2.00			
3.00	SUBPROVIDER - IPF		0	0	3.00			
4.00	SUBPROVIDER - IRF		0	0	4.00			
5.00	Subprovider - (Other)		0	0	5.00			
6.00	Swing Beds - SNF		0	0	6.00			
7.00	Swing Beds - NF		0	0				
8.00	SKILLED NURSING FACILITY		0	0	0.00			
9.00	NURSING FACILITY		0	0	9.00			
10.00	OTHER LONG TERM CARE I				10.00			
11.00	Hospital-Based HHA		0	0	11.00			
12.00	AMBULATORY SURGICAL CENTER (D. P.) I		0	0				
13.00	Hospi tal -Based Hospi ce		0	0				
14.00	Hospital-Based Health Clinic RHC		0	0	14.00			
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00			
16.00	Hospital-Based-CMHC		0	0	16.00			
16. 10	Hospital-Based-CMHC 10		0	0				
17.00	RENAL DIALYSIS I		0	0				
18.00	Other		0	0	18.00			

Heal th	Financial Systems LUTHERAN MUSCULO	SKELETAL CENTER	2	In Lie	eu of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C		Peri od:	Worksheet S-1		
				From 01/01/2022			
				To 12/31/2022			
					5/31/2023 9:1	3 am	
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	3 divided by li	ne 202 column	8)	0. 088420	1.00	
	Medicaid (see instructions for each line)	2					
2.00	Net revenue from Medicaid				7, 841, 273	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid	?			N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supple			i d?	N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental paymen	ts from Medicai	d		0	5.00	
6.00	Medi cai d charges				63, 901, 926	6.00	
7.00	Medicaid cost (line 1 times line 6)				5, 650, 208	7.00	
8.00	Difference between net revenue and costs for Medicaid prog	ram (line 7 min	nus sum of lir	es 2 and 5; if	0	8.00	
	< zero then enter zero)						
0.00	Children's Health Insurance Program (CHIP) (see instruction	ns for each lin	ie)			0.00	
9.00	Net revenue from stand-alone CHIP				0	9.00	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00 11.00	
12.00	Difference between net revenue and costs for stand-alone Cl	HID (line 11 mi	nus lino 0. i	f < zero then		12.00	
12.00	enter zero)		nus i ne 🧃 i		0	12.00	
	Other state or local government indigent care program (see	instructions f	or each line)				
13.00	Net revenue from state or local indigent care program (Not			)	0	13.00	
14.00	Charges for patients covered under state or local indigent				0	14.00	
	10)		•				
15.00	State or local indigent care program cost (line 1 times lin	ne 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local	l indigent care	e program (lir	e 15 minus line	0	16.00	
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid,	CHIP and stat	e/local indig	ent care progra	ms (see		
17 00	instructions for each line) Private grants, donations, or endowment income restricted	te Curdine cher			0	17 00	
17.00 18.00	Government grants, appropriations or transfers for support					17.00 18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and			(sum of lines	0	19.00	
17.00	8, 12 and 16)	rocar rhargent	cure programe			17.00	
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col. 2)		
			1.00	2.00	3.00		
	Uncompensated Care (see instructions for each line)				0.044.050		
20.00	Charity care charges and uninsured discounts for the entire	e facility	3, 841, 05	3 C	3, 841, 053	20.00	
21.00	(see instructions) Cost of patients approved for charity care and uninsured di	iccounts (coo	339, 62	.6 C	339, 626	21 00	
21.00	instructions)	iscounts (see	339,02	.0	339,020	21.00	
22.00	Payments received from patients for amounts previously write	tten off as		0 0	0	22.00	
22.00	charity care				Ĵ	22.00	
23.00	Cost of charity care (line 21 minus line 22)		339, 62	6 C	339, 626	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for pa		ond a length	of stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent of				_		
25.00	If line 24 is yes, enter the charges for patient days beyon	nd the indigent	care program	's length of	0	25.00	
24 00	stay limit	· instructions)			1 051 221	24 00	
26.00 27.00	Total bad debt expense for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital com				1, 851, 321 17, 422		
27.00	Medicare allowable bad debts for the entire hospital complete				26, 802		
27.01	Non-Medicare bad debt expense (see instructions)		1, 824, 519				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad deb	170, 704					
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	- 5.120.100 (000			510, 330		
	Total unreimbursed and uncompensated care cost (line 19 plu	us line 30)			510, 330		
					•		

		)F EXPENSES	FIOVICEI CO	F	eriod: rom 01/01/2022	Worksheet A	narod.
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	o 12/31/2022 Reclassificati ons (See A-6)	5/31/2023 9:13 Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	·····					
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 119, 549				1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		6, 617, 198 0	6, 617, 198 0	267, 534 0	6, 884, 732 0	2.00 3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	16, 442	160, 436	176, 878	-	5, 272, 803	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	5, 224, 587	52, 711, 186			49, 632, 109	5.00
7.00	00700 OPERATION OF PLANT	89, 917	1, 770, 916			2, 494, 228	
3.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 2, 069	157, 392 541, 683	157, 392 543, 752		157, 392 532, 798	
10.00	01000 DI ETARY	2,009	224, 530	224, 530	-10, 934	224, 530	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	714, 956	100, 198			959, 049	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	675, 471	2, 590, 174			2, 435, 164	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	268, 040 25, 675	1, 042, 347 738, 069	1, 310, 387 763, 744	-896, 345 -6, 268	414, 042 757, 476	
17.00	01700 SOCIAL SERVICE	23, 075	0	0	0, 200	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 21.00	02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20.00
22.00	02200 I &R SERVICES-SALART & FRINGES APPRV	0	0	0	0	0	21.00
23.00	02300 PARAMED ED PRGM	0	0	0	0	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 631, 728	909, 991	3, 541, 719	-11, 060	3, 530, 659	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0	0	0	0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0	0	0	0	41.00 43.00
44.00	04400 SKI LLED NURSING FACILITY	0	0	0	0	0	43.00
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	ANCI LLARY SERVI CE COST CENTERS	5, 791, 158	31, 054, 411	36, 845, 569	-20, 856, 540	15, 989, 029	50.00
51.00	05100 RECOVERY ROOM	1, 941, 941	631, 294			2, 572, 954	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	377, 575			377, 575	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA_SOUND	409, 240 0	463, 810 4, 403	873, 050 4, 403	-220, 455 0	652, 595 4, 403	54.00 54.01
	05500 RADI OLOGY-THERAPEUTI C	0	4, 403	4,403		4,403	
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 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58.00 59.00
59.00 50.00	06000 LABORATORY	22, 030	439, 480	461, 510	-212	461, 298	60.00
50.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
52.00 53.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00 63.00
53.00 54.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
55.00	06500 RESPI RATORY THERAPY	1, 981	32, 572	34, 553	0	34, 553	
66.00	06600 PHYSI CAL THERAPY	2, 241, 619	608, 389	2, 850, 008	762, 939	3, 612, 947	66.00
57.00	06700 OCCUPATIONAL THERAPY	742, 806	136, 352	879, 158		0	67.00
58.00 59.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	97, 477 25, 304	6, 695 35, 222	104, 172 60, 526	-104, 172 -76	0 60, 450	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	23, 304	0,222	00, 520	0	00, 430	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	865, 962	865, 962	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20, 066, 443	20, 066, 443	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	887, 517 0	887, 517 0	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
38.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
39.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC 09100 EMERGENCY	0	0	0		0	90.00 91.00
			0		0	0	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

Health Financial Systems LU	THERAN MUSCULOSK	ELETAL CENTER		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0168	Peri od:	Worksheet A	
				From 01/01/2022	Data (Tima Daa	
				To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
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 OLD 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 ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE		0		0 0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		0 0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	20, 922, 441	102, 473, 872	123, 396, 3	13 16, 499	123, 412, 812	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 PHYSI CLANS' PRI VATE OFFI CES	1, 217	18, 232	19, 4	49 - 3, 360	16, 089	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 SPORTS MEDICINE	2, 638, 637	620, 057	3, 258, 6	94 –13, 139	3, 245, 555	194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	23, 562, 295	103, 112, 161	126, 674, 4	56 0	126, 674, 456	200.00

EULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EXPENSES	Provider CCN: 15	From 01/01/202	
				To 12/31/202	22 Date/Time Prepar 5/31/2023 9:13 a
	Cost Center Description	Adjustments (See A-8) F	Net Expenses or Allocation		
		6.00	7.00		
00	GENERAL SERVICE COST CENTERS	01 502	4 (12 (07		
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	81, 593 156, 017	4, 613, 697 7, 040, 749		
. 00	00300 OTHER CAP REL COSTS	130, 017	0		
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 272, 803		
. 00	00500 ADMI NI STRATI VE & GENERAL	-34, 119, 612	15, 512, 497		Į
00	00700 OPERATION OF PLANT	0	2, 494, 228		
00	00800 LAUNDRY & LINEN SERVICE	0	157, 392		8
00 0. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	532, 798 224, 530		10
2.00	01200 MAINTENANCE OF PERSONNEL	0	0		12
3.00	01300 NURSI NG ADMI NI STRATI ON	0	959, 049		1:
4.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 435, 164		14
	01500 PHARMACY	0	414, 042		1!
	01600 MEDI CAL RECORDS & LI BRARY	-58	757, 418		10
	01700 SOCIAL SERVICE	0	0		1
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0		18
	02000 NURSI NG PROGRAM	0	0		20
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	o		2
2.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	О		22
3.00	02300 PARAMED ED PRGM	0	0		23
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 520 / 50		
	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	0	3, 530, 659 0		30
	03200 CORONARY CARE UNIT	0	0		3
	03300 BURN INTENSIVE CARE UNIT	0	0		3
	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34
0. 00	04000 SUBPROVI DER – I PF	0	0		40
1.00	04100 SUBPROVI DER – I RF	0	0		41
	04300 NURSERY	0	0		43
4.00 5.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		44
6.00	04600 OTHER LONG TERM CARE	0	0		4
0.00	ANCI LLARY SERVICE COST CENTERS	0			
0. 00	05000 OPERATING ROOM	0	15, 989, 029		50
1. 00	05100 RECOVERY ROOM	0	2, 572, 954		51
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-335, 866	41, 709 652, 595		53
	03630 ULTRA SOUND	0	4, 403		54
5.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 403		5
	05600 RADI OI SOTOPE	0	o		50
7.00	05700 CT SCAN	0	0		5
	05800 MRI	0	0		58
	05900 CARDI AC CATHETERI ZATI ON	0	0		59
		0	461, 298		60
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63
	06400 I NTRAVENOUS THERAPY	0	О		64
	06500 RESPI RATORY THERAPY	0	34, 553		6
	06600 PHYSI CAL THERAPY	-3, 103	3, 609, 844		60
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	U O		6
	06900 ELECTROCARDI OLOGY	0	60, 450		60
	07000 ELECTROENCEPHALOGRAPHY	0	0		70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	865, 962		7
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	20, 066, 443		72
	07300 DRUGS CHARGED TO PATIENTS	0	887, 517		7:
	07400 RENAL DIALYSIS	0	0		74
	07500 ASC (NON-DI STI NCT PART)	0	0		7!
1.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		7
3. 00	08800 RURAL HEALTH CLINIC	0	0		88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ő		80
	09000 CLINIC	0	ō		90
	09100 EMERGENCY	0	О		9
2.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				92
1 00	OTHER REIMBURSABLE COST CENTERS				
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		94
	UVJUULANUL JERVIULJ	0	o		9

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0168		Worksheet A
			From 01/01/2022	
			To 12/31/2022	Date/Time Prepared: 5/31/2023 9:13 am
Cost Center Description	Adjustments	Net Expenses		373172023 <del>7</del> . 13 alli
cost center bescription		For Allocation		
	6.00	7.00		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	o		98.00
99. 00 09900 CMHC	0	0		99.00
99. 10 09910 CORF	0	o		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00 11300 INTEREST EXPENSE	0	0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116.00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-34, 221, 029	89, 191, 783		118.00
NONREI MBURSABLE COST CENTERS	<u>г</u>			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	16, 089		192.00
193. 00 19300 NONPAI D WORKERS	0	0		193.00
194. 00 07950 SPORTS MEDI CI NE	0	3, 245, 555		194.00
194. 01 07951 SENI OR CI RCLE	0	0		194.01
200.00   TOTAL (SUM OF LINES 118 through 199)	-34, 221, 029	92, 453, 427		200.00

CLASS	SIFICATIONS			Provider CC	N: 15-0168	Peri od:	Worksheet A-	6
						From 01/01/2022 To 12/31/2022	Date/Time Pr 5/31/2023 9:	epare
		Increases				-1	0/01/2020 /1	
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - EMPLOYEE BENEFITS							
00	EMPLOYEE BENEFITS DEPARTMENT	4.00		<u>5, 095, 9</u> 25				1.
	0		0	5,095,925				
	B - RENTAL AND LEASE							
00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 667, 900				1
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	266, 077				2
00		0.00	o	0				3
00		0.00	0	0				4
00		0.00	o	0				6
0		0.00	0	0				7
0		0.00	0	0				9
00		0.00	Ő	0				11
00		0.00	0	0				12
00		0.00	0	0				13
00				0				14
		0.00	0	U				
00		0.00	º	0				15
			0	2, 933, 977				
	C - OTHER CAPITAL COST	1.00		170.000				
00	CAP REL COSTS-BLDG & FIXT	1.00	0	173, 933				1
00	CAP REL COSTS-BLDG & FIXT	1.00	0	570, 722				2
00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u> </u>				3
	0		0	746, 112				
	D - REPAIRS & MAINTENANCE							
00	OPERATION OF PLANT	7.00	0	633, 582				1
00		0.00	0	0				2
00		0.00	0	0				4
00		0.00	0	0				5
00		0.00	0	0				6
00		0.00	0	0				7
00		0.00	0	0				8
0		0.00	0	0				9
00		0.00	Ő	0				10
00		0.00	0	0				11
00		0.00	0	0				12
00			0	0				13
		0.00						
00		0.00	0	0				15
00		0.00	0	0				16
			0	633, 582				-
	E - CHIEF NURSING OFFICER	40.00	440.045					
0	NURSING ADMINISTRATION	<u>13.00</u>	143, 965	<u>0</u>				1
			143, 965	0				-
	F - MEDICAL SUPPLIES							-
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	865, 962				1
	PATI ENT							
0	IMPL. DEV. CHARGED TO	72.00	0	20, 066, 443				2
	PATI ENTS							
0	PHYSICAL THERAPY	66.00	0	1, 894				3
		†		20, 934, 299				
	G - DRUGS/IV SOLUTIONS							1
0	DRUGS CHARGED TO PATIENTS	73.00	0	887, 517				1
-			<u>_</u>	887, 517				1
	<u> </u>		U	007,017				-

1.00

2.00

500.00

LUTHERAN MUSCULOSKE	LETAL CENTER	
	Provider CCN: 15-0168	Perio From

CCN:	12-0168	Peri oa:
		From 01/0

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

						To 12/31/2022	Date/Time Prepared: 5/31/2023 9:13 am
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS	5 00			-1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	º	<u>5, 095, 925</u>		o	1.00
			0	5, 095, 925			
1.00	B - RENTAL AND LEASE ADMI NI STRATI VE & GENERAL	5.00	0	2,043,593	3 1	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,043,593			2.00
3.00	NURSI NG ADMI NI STRATI ON	13.00	0	43, 032		0	3. 00
4.00	MEDI CAL RECORDS & LI BRARY	16.00	0	6, 268		0	4. 00
6.00	OPERATING ROOM	50.00	0	435, 015		0	6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	o	212, 610		o	7.00
9.00	PHYSI CAL THERAPY	66.00	o	153, 373		0	9.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	28		0	11.00
12.00	SPORTS MEDICINE	194.00	Ő	12, 759		0	12.00
13.00	ELECTROCARDI OLOGY	69.00	o	17		o	13.00
14.00	OPERATION OF PLANT	7.00	Ő	187		o	14.00
15.00	OCCUPATI ONAL THERAPY	67.00	0	26, 425		o	15.00
			<del>_</del>	2,933,977		7	
	C - OTHER CAPITAL COST	I	i		1	1	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	746, 112	2 1	2	1.00
2.00		0.00	0	Ċ	) 1	3	2.00
3.00		0.00	0	C	) 1	2	3.00
	0	+	0	746, 112		1	
	D - REPAIRS & MAINTENANCE	· · · ·					
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	274, 069	9	0	1.00
2.00	HOUSEKEEPI NG	9.00	0	10, 954	1	o	2.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	36, 961	1	0	4.00
5.00	PHARMACY	15.00	0	8, 828	3	o	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	11, 060	D	o	6.00
7.00	OPERATING ROOM	50.00	0	237, 114	1	o	7.00
8.00	RECOVERY ROOM	51.00	0	281		0	8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 845		0	9.00
10.00	LABORATORY	60.00	0	212		0	10.00
11.00	PHYSI CAL THERAPY	66.00	0	42, 140		0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 332		0	12.00
13.00	SPORTS MEDICINE	194.00	0	380		0	13.00
15.00	OCCUPATI ONAL THERAPY	67.00	0	347		0	15.00
16.00	ELECTROCARDIOLOGY	<u>69.</u> 00		59		ol	16.00
			0	633, 582	2		
1 00	E - CHIEF NURSING OFFICER	5.00	143, 965			0	1.00
1.00	ADMI NI STRATI VE & GENERAL		143, 965	0	<u></u>	0	1.00
	F - MEDI CAL SUPPLI ES		143, 905		<u>ן</u>		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	749, 888		0	1.00
2.00	OPERATING ROOM	50.00	0	20, 184, 411		0	2.00
3.00	OF ERATTING ROOM	0.00	0	20, 184, 411		0	3. 00
5.00			— — — <del>o</del>	20, 934, 299			5.00
	G - DRUGS/IV SOLUTIONS		9	20, 754, 275			
1.00	PHARMACY	15.00	0	887, 517	7	0	1.00
1.00				887, 517			1.00
	H - MISC DEPTS		U	007, 317	<u>'</u>		
1.00	OCCUPATIONAL THERAPY	67.00	742, 806	109, 580	0	0	1.00
2.00	SPEECH PATHOLOGY	68.00	97, 477	6, 695		0	2.00
2.00			840, 283	<u>0,0</u> 95		Ĭ	2.00
500 00	Grand Total: Decreases					1	500.00
500.00	Grand Total: Decreases		984, 248	31, 347, 687	7		

RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/ To 12/31/		Worksheet A-7 Part I Date/Time Prep 5/31/2023 9:13	pared:
				Acqui si ti on				
		Begi nni ng Bal ances	Purchases	Donati on	Total	1	Disposals and Retirements	
		1.00	2.00	3.00	4.00		5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
. 00	Land	0	0		0	0	0	1.0
2.00	Land Improvements	26, 765	0		0	0	0	2.0
3.00	Buildings and Fixtures	735, 818	129, 560		0 129	, 560	0	3.0
I. 00	Building Improvements	8, 335, 331	61, 635		0 61	, 635	0	4.0
5.00	Fixed Equipment	1, 936, 972	426, 361		0 426	, 361	0	5.0
b. 00	Movable Equipment	21, 496, 556	1, 789, 874		0 1, 789	9, 874	0	6.0
. 00	HIT designated Assets	13, 366	0		0	0	0	7.0
3.00	Subtotal (sum of lines 1-7)	32, 544, 808	2, 407, 430		0 2, 407	, 430	0	8.0
9.00	Reconciling Items	0	0		0	0	0	9.0
0.00	Total (line 8 minus line 9)	32, 544, 808	2, 407, 430		0 2,407	, 430	0	10.0
		Endi ng Bal ance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES						
. 00	Land	0	0					1.0
2.00	Land Improvements	26, 765	0					2.0
8.00	Buildings and Fixtures	865, 378	0					3.0
l. 00	Building Improvements	8, 396, 966	0					4.0
5.00	Fixed Equipment	2, 363, 333	0					5.0
o. 00	Movable Equipment	23, 286, 430	0					6.0
. 00	HIT designated Assets	13, 366	0					7.0
3.00	Subtotal (sum of lines 1-7)	34, 952, 238	0					8. 0
9.00	Reconciling Items	0	0					9. (
0.00	Total (line 8 minus line 9)	34, 952, 238	0					10.0

Heal th	Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0168	Period:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		pared <sup>.</sup>
					10 12/01/2022	5/31/2023 9:1	<u>3 am</u>
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 119, 549	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6, 617, 198	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	7, 736, 747	0		0 0	0	3.00
		SUMMARY O					
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 119, 549				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6, 617, 198				2.00
3.00	Total (sum of lines 1-2)	0	7, 736, 747				3.00

2.00         CAP REL COSTS-MVBLE EQUIP         0         0         0         0         6,773,215         266,077         2.00           3.00         Total (sum of lines 1-2)         0         0         0         0         7,974,357         2,933,977         3.00           SUMMARY OF CAPITAL           Cost Center Description           Interest Insurance (see instructions)         Taxes (see instructions)         Other of cols.9           11.00         12.00         13.00         14.00         15.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         173,933         570,722         0         4,613,697         1.00	Heal th	n Financial Systems LL	THERAN MUSCULO	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10	
Cost Center Description         Gross Assets         Capitalized Leases         Gross Assets for Ratio (col. 1 - col. 2)         Response Instructions)         Insurance           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS-BLD6 & FIXT         9,289,109         0         9,289,109         0.255766         0         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         25,663,129         0         25,663,129         0.255766         0         2.00           3.00         Total (sum of lines 1-2)         34,952,238         0         34,952,238         1.000000         3.00           Cost Center Description         Taxes         Other Capital-Relate d Costs         Total (sum of col s. 5 through 7)         Depreciation         Lease           0         CAP REL COSTS-BLDG & FIXT         0         0         0         1.00         2.667,900         1.00           2.00         CAP REL COSTS-BLDG & FIXT         0         0         0         0         1.00         2.667,900         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         0         0         0         0         1.00         2.667,900         1.00           2.00	RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	rom 01/01/2022	Part III Date/Time Prem	bared:	
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         I. 00         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS-BLDG & FIXT         9, 289, 109         0         9, 289, 109         0.25, 663, 129         0.25, 663, 129         0.25, 663, 129         0.300         0.00000         0.00 <td< td=""><td></td><td></td><td>COMI</td><td>PUTATION OF RAT</td><td>FI OS</td><td>ALLOCATION OF</td><td>OTHER CAPI TAL</td><td></td></td<>			COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         9,289,109         0         9,289,109         0.265766         0         1.00           2.00         CAP REL COSTS-BLDG & FIXT         9,289,109         0         9,289,109         0.25,663,129         0.734234         0         2.00           3.00         Total (sum of lines 1-2)         34,952,238         0         34,952,238         1.000000         0         3.00         3.00           Cost Center Description         Taxes         Other         Total (sum of costs 5 through 7)         Depreciation         Lease           1.00         CAP REL COSTS-BLDG & FIXT         0         0         0         9.00         10.00           PART 111 - RECONCILLIATION OF CAPITAL COSTS CENTERS         Taxes         Other         Total (sum of lines 7)         Lease         1.00           1.00         CAP REL COSTS-MUBLE EQUIP         0         0         0         1.201,142         2,667,900         1.00           2.00         CAP REL COSTS-MUBLE EQUIP         0         0         0         0         7,974,357         2,933,977         3.00           3.00         Total (sum of lines 1-2)         0         0         0         7,974,357         2,933,977         3.00           1.00		Cost Center Description		Leases	for Ratio (col. 1 - col. 2)	instructions)			
1.00       CAP REL COSTS-BLDG & FIXT       9, 289, 109       0       9, 289, 109       0.265766       0       1.00         2.00       CAP REL COSTS-MVBLE EQUIP       25, 663, 129       0.25, 663, 129       0.734234       0       2.0         3.00       Total (sum of lines 1-2)       34, 952, 238       0       34, 952, 238       1.000000       0       3.00         ALLOCATION OF OTHER CAPITAL         Cost Center Description         Total (sum of costs         Total (sum of costs         Cost Center Description       Taxes       Other Capital -Relate       Total (sum of lines 1-2)       0       0       0       1.00         ALLOCATION OF OTHER CAPITAL         Cost Center Description       Taxes       Other Capital -Relate       Total (sum of lines 1-2)       0       0       0       1.00       1.00         SUMMARY OF CAPITAL COSTS CENTERS         1.00       CAP REL COSTS-MVBLE EQUIP       0       0       0       7.974, 357       2.933, 977       3.00         SUMMARY OF CAPITAL         Cost Center Description       Interest       Insurance (see instructions)       Taxes (see of ther capital -Relate capital -Relate capital -Relate capital -Re				2.00	3.00	4.00	5.00		
2.00         CAP REL COSTS-MVBLE EQUIP         25,663,129         0         25,663,129         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0.734234         0         2.00         0         0.00         0.00         0.00         0.00	1 00			0	0 200 100	0.0/57//	0	1 00	
3.00         Total (sum of lines 1-2)         34,952,238         0         34,952,238         1.00000         0         3.00           ALLOCATION OF OTHER CAPITAL         SUMMARY OF CAPITAL							Ű		
PART 111 - RECONCILIATION OF CAPITAL       OIL OCATION OF OTHER CAPITAL       SUMMARY OF CAPITAL         Cost Center Description       Taxes       Other Capital -Relate d Costs       Total (sum of cols. 5 through 7)       Depreciation       Lease         1.00       PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS       0       0       0       1.00       1.201, 142       2.667, 900       1.00         2.00       CAP REL COSTS-BLDG & FIXT       0       0       0       0       6.773, 215       2.667, 900       1.00         3.00       Total (sum of lines 1-2)       0       0       0       0       7, 974, 357       2, 933, 977       3.00         SUMMARY OF CAPITAL       Interest       Insurance (see instructions)       Taxes (see instructions)       Other d Costs (see instructions)       Total (2) (sum of cols. 9 through 14)         1.00       12.00       13.00       14.00       15.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS       0       173, 933       570, 722       0       4, 613, 697       1.00							Ű		
Cost Center Description       Taxes       Other       Total (sum of cols . 5       Cost center Description       Lease         Taxes       Other       Total (sum of cols . 5       Depreciation       Lease         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         O       O       O       1.00       CAP REL COSTS-BLDG & FIXT       O       O       O       1.00       Cost Center Description       Interest       Total (sum of lines 1-2)       Cost Center Description       Interest       Insurance (see instructions)       Total (2) (sum of cols. 9         O       O       Total (20 (sum of cols. 9)       Total (2) (sum of cols. 9         Interest       Insurance (see instructions)       Total (2) (sum of cols. 9         O       O       O       Total (2) (sum of cols. 9         Interest       Insurance (see instructions)       Total (2) (sum of cols. 9       Total (2) (sum of cols. 9         Intoo       1.00 <th colspa<="" td=""><td>3.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>3.00</td></th>	<td>3.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3.00</td>	3.00							3.00
Capi tal -Rel ate d Costs         col s. 5 through 7)         display           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         6.00         7.00         8.00         9.00         10.00           1.00         CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT 2.00         0         0         0         1.201,142         2,667,900         1.00           2.00         CAP REL COSTS-MVBLE EQUIP 3.00         0         0         0         0         7,974,357         2,933,977         3.00           3.00         Total (sum of lines 1-2)         0         0         0         7,974,357         2,933,977         3.00           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other of col s. 9 through 14)         Total (2) (sum of col s. 9 through 14)           11.00         12.00         13.00         14.00         15.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         0         173,933         570,722         0         4,613,697         1.00			ALLOON	ITON OF OTHER (		30000200	I GAITIAL		
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         0         0         0         1.00         CAP REL COSTS-BLDG & FIXT         0         0         0         1.00         1.201,142         2,667,900         1.00           2.00         CAP REL COSTS-MVBLE EQUIP         0         0         0         0         1,201,142         2,667,900         1.00           3.00         Total (sum of lines 1-2)         0         0         0         0         7,974,357         2,933,977         3.00           SUMMARY OF CAPITAL           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other d Costs (see instructions)         Total (2) (sum of col s. 9 through 14)           11.00         12.00         13.00         14.00         15.00         14.00         15.00		Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
6.00         7.00         8.00         9.00         10.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         0         0         0         1,201,142         2,667,900         1.00           2.00         CAP REL COSTS-BLDG & FIXT         0         0         0         0         6,773,215         266,077         2.00           3.00         Total (sum of lines 1-2)         0         0         0         0         7,974,357         2,933,977         3.00           SUMMARY OF CAPITAL           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other         Total (2) (sum of cols. 9           11.00         12.00         13.00         14.00         15.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         CAP REL COSTS-BLDG & FIXT         0         173,933         570,722         0         4,613,697         1.00		•		Capi tal -Rel ate	cols. 5				
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         CAP REL COSTS-BLDG & FIXT         0         0         0         1, 201, 142         2, 667, 900         1, 00           2.00         CAP REL COSTS-MVBLE EQUIP         0         0         0         0         6, 773, 215         266, 077         2.00           3.00         Total (sum of lines 1-2)         0         0         0         0         7, 974, 357         2, 933, 977         3.00           SUMMARY OF CAPITAL           Cost Center Description           Interest         Insurance (see instructions)         Taxes (see instructions)         Other d Costs (see instructions)         Total (2) (sum of cols. 9 through 14)           11.00         12.00         13.00         14.00         15.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         CAP REL COSTS-BLDG & FIXT         0         173, 933         570, 722         0         4, 613, 697         1.00				d Costs	through 7)				
1.00       CAP REL COSTS-BLDG & FIXT       0       0       0       1, 201, 142       2, 667, 900       1, 00         2.00       CAP REL COSTS-MVBLE EQUIP       0       0       0       0       6, 773, 215       266, 077       2, 00         3.00       Total (sum of lines 1-2)       0       0       0       0       7, 974, 357       2, 933, 977       3, 00         SUMMARY OF CAPITAL         Cost Center Description         Interest Insurance (see instructions)       Taxes (see instructions)       0       0       0       1, 00       12, 00       13, 00       14, 00       15, 00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       173, 933       570, 722       0       4, 613, 697       1, 00				7.00	8.00	9.00	10.00		
2.00         CAP REL COSTS-MVBLE EQUIP         0         0         0         0         6,773,215         266,077         2.00           3.00         Total (sum of lines 1-2)         0         0         0         0         7,974,357         2,933,977         3.00           SUMMARY OF CAPITAL           Cost Center Description           Interest Insurance (see instructions)         Taxes (see instructions)         Other of cols.9           11.00         12.00         13.00         14.00         15.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         173,933         570,722         0         4,613,697         1.00			ENTERS	1					
3.00         Total (sum of lines 1-2)         0         0         0         7,974,357         2,933,977         3.00           SUMMARY OF CAPITAL           Cost Center Description           Interest         Insurance (see instructions)         Taxes (see instructions)         Other Capital -Relate d Costs (see instructions)         Total (2) (sum of cols. 9 through 14)           11.00         12.00         13.00         14.00         15.00           PART III - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         173,933         570,722         0         4,613,697         1.00			0	0	(			1.00	
SUMMARY OF CAPITAL         Cost Center Description       Interest Insurance (see instructions)       Taxes (see Other Capital -Relate of			0	0	(			2.00	
Cost Center Description       Interest       Insurance (see instructions)       Taxes (see instructions)       Other       Total (2) (sum of col s. 9 through 14)         11.00       12.00       13.00       14.00       15.00         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       173,933       570,722       0       4,613,697       1.00	3.00	Total (sum of lines 1-2)	0	0	(		2, 933, 977	3.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS     0     173, 933     570, 722     0     4, 613, 697     1.00				SL	JMMARY OF CAPI	IAL			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS     0     173, 933     570, 722     0     4, 613, 697     1.00		Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         11.00         12.00         13.00         14.00         15.00           1.00         CAP REL COSTS-BLDG & FIXT         0         173,933         570,722         0         4,613,697         1.00		•							
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         11.00         12.00         13.00         14.00         15.00           1.00         CAP REL COSTS-BLDG & FIXT         0         173,933         570,722         0         4,613,697         1.00						d Costs (see	through 14)		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS           1.00         CAP REL COSTS-BLDG & FIXT         0         173, 933         570, 722         0         4, 613, 697         1.00						instructions)	-		
1. 00 CAP REL COSTS-BLDG & FIXT 0 173, 933 570, 722 0 4, 613, 697 1. 0				12.00	13.00	14.00	15.00		
			-	L	I	T.			
2.00 ICAP REL COSTS-MVBLE EQUIP I 0  1.457  0  0  7.040.749  2.00			u u					1.00	
			0			•		2.00	
3.00  Total (sum of lines 1-2)   0  175,390  570,722  0  11,654,446  3.00	3.00	lotal (sum of lines 1-2)	0	175, 390	570, 722	2  0	11, 654, 446	3.00	

	Financial Systems	LUT	HERAN MUSCULOS	SKELETAL CENTER		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Date/Time Pre 5/31/2023 9:13	pared:
				Expense Classification of To/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
	COSTS-BLDG & FIXT (chapter 2)						
2.00 3.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00		
4.00	(chapter 2) Trade, quantity, and time		o		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0	ADMI NI STRATI VE & GENERAL	5.00		
8.00	stations excluded) (chapter 21) Television and radio service	A	-16.377	ADMI NI STRATI VE & GENERAL	5.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)				0.00		
	Provi der-based physician adjustment	A-8-2	-373, 063		0.00	0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1, 514, 064			0	12.00
	Laundry and linen service Cafeteria-employees and guests		0		0.00	0	
	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	В	-58	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
	Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28.00
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	о	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33.00	RENTAL INCOME	В	-9, 173	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.00

Health Financial Systems	LU	THERAN MUSCULOS	SKELETAL CENTER	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0168	Peri od:	Worksheet A-8	
				From 01/01/2022 To 12/31/2022		pared: 3 am
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.01
(3)						
33. 02 TELEVISION DEPRECIATION	A	-3, 103	PHYSICAL THERAPY	66.00	0	33.02
33.03 FITNESS REVENUE	В	-309, 935	ADMINISTRATIVE & GENERAL	5.00	0	33.03
34.00 OTHER MISC REVENUE	В	-35,097	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 MARKETING EXPENSES	A	-794, 115	ADMINISTRATIVE & GENERAL	5.00		35.00
36.00 LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5.00		36.00
37.00 CHARI TABLE CONTRI BUTI ONS	A		ADMINISTRATIVE & GENERAL	5.00		37.00
38.00 PHYSICIAN RECRUITING	A		ADMINISTRATIVE & GENERAL	5.00		38.00
39.00 MINORITY INTEREST	A		ADMI NI STRATI VE & GENERAL	5.00		39.00
40.00 PENALTI ES	A		ADMINISTRATIVE & GENERAL	5.00		40.00
41.00 LEGAL FEES	A	-50, 438	ADMINISTRATIVE & GENERAL	5.00		41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
(3) 50.00  TOTAL (sum of lines 1 thru 49)		-34, 221, 029				50.00
(Transfer to Worksheet A,	′	- 34, 221, 029				30.00
column 6, line 200.)						
					1	L

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

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

Heal th	Financial Systems	LUTHERAN MUSCUL	OSKELETAL CENTER	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM			Peri od:	Worksheet A-8	
OFFICE				From 01/01/2022		
				To 12/31/2022		
					5/31/2023 9:1	3 am
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		r			
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3.01	0.00			0	0	3.01
3.02	0.00			0	0	3.02
3.03	0.00			0	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
3.07	0.00			0	0	3.00
3.07	0.00			0	0	3.07
3.08	0.00			0	0	3.08
				0	0	
3.10	0.00			0	0	3.10
3.11	0.00			0	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16		ADMINISTRATIVE & GENERAL	CONTRACT MANAGEMENT	0	83, 250	3.16
4.00		CAP REL COSTS-BLDG & FIXT	PASI Capital Costs - Bldg &	3, 260	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	681	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	PASI Operating Costs	232, 850	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	Shared Service Center Alloca	1, 822, 224	830, 868	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix	78, 333	0	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	New Capital - Movable Equipm	164, 509	0	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	Non-Capital Home Office Cost	3, 061, 981	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	Malpractice Costs	44, 454	171, 377	4.07
4.08			Management Fees	0	3, 370, 691	4.08
4.09		ADMINISTRATIVE & GENERAL	401K Fees	0	4, 900	4.09
4.10			Audit Fees	0	88, 575	4.10
4, 11		ADMI NI STRATI VE & GENERAL	Corporate Overhead Allocatio	0	1, 824, 457	4, 11
4.12		ADMINI STRATI VE & GENERAL	HIIM Allocation	0	353, 830	4. 12
4.12		ADMINI STRATI VE & GENERAL	PASI Lien Unit Collection Fe		194, 408	4.12
4. 13 5. 00	TOTALS (sum of lines 1-4).	COMPANY CONCRETE		5, 408, 292	6, 922, 356	5.00
5.00	Transfer column 6, line 5 to			5, 400, 292	0, 922, 330	5.00
	Worksheet A-8, column 2,					
	line 12.					
		l pscripts as appropriate) are t			<u> </u>	

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

1103 110	Deen posted to worksheet A,	corumns ranu/or z, the amount		ouru be murcateu micorullin 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

1 Of Inio di						
6.00	В	COMMUNITY HEALT	60.00	COMMUNITY HEALT	60.00	6.00
7.00	В	LUTHERAN HEALTH	40.00	LUTHERAN HEALTH	40.00	7.00
8.00	В	HOSPI TAL LAUNDR	100.00	HOSPITAL LAUNDR	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

Heal th	Financial Systems	LUTHERAN MUSCUL	OSKELETAL CENTE	ER	In Lie	eu of Form CMS-	2552-10
STATEME	INT OF COSTS OF SERVICES FROM	I RELATED ORGANIZATIONS AND HO	ME Provider	CCN: 15-0168	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2022		
					To 12/31/2022	Date/Time Pre 5/31/2023 9:	epared: 13 am
				Related Orga	nization(s) and/o		
				J			
	Symbol (1)	Name	Percentage of	1	Vame	Percentage of	
			Ownership			Ownership	
	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 organi zati on.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS         Provider COX: 15-0168         Perod: From 01/01/2020 To 12/31/2023         Worksheet A-8-1 Date/Time Prepared: 5/31/2023 9:13 am           Adjustments (col 4 minus (col 5)         Met Mikst. A-7 Ref. (col 5)         Net Mikst. A-7 Ref. (col 6)         Net Mikst. A-7 Ref. (col 7)         Net Mikst. Net Mikst. Net Mikst. Net Mikst. Net Mikst. Net Mikst. Net Mi	Heal th	Financial System	IS	LUTHERAN MUSCULOSKI	ELETAL CENTER	In Lieu of Form	CMS-2552-10
Note sold         To         12/31/2022         Date/Time Prepared: 5/31/2023 9:13 am           Net (col. 4 minus (col. 5)*         Wist. A-7 Ref. (col. 5)*         Date/Time Prepared: 5/31/2023 9:13 am           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:         1.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED         1.00           1.00         0         0         0         0         0         1.00           3.00         0         0         0         0         0         0         1.00           3.02         0         0         0         0         0         3.02         3.02         3.02           3.04         0         0         0         0         3.02         3.04         3.04         3.04         3.04           3.05         0         0         0         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.03         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.05         3.02			SERVICES FROM R	ELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0168		t A-8-1
Net Adjustents (col. 5)*         Wkst. A-7 Ref. 6.00         5/31/2023 9:13 am           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED Hell OFFICE COSTS.         1.00           1.00         0         0         0           3.00         0         0         3.00           3.01         0         0         3.00           3.02         0         0         3.00           3.04         0         0         3.00           3.05         0         0         3.00           3.06         0         0         3.00           3.07         0         0         3.00           3.08         0         0         3.00           3.11         0         0         3.00           3.11         0         9         3.10           3.12         0         9         3.10           3.13         0         9         3.13           3.14         0         9         3.13           3.14         0         9         3.13           3.14         0         9         3.13           3.14         0         9         3.13	OFFI CE	COSTS					Drananad
Net (c)         West.         A-7 Ref.           -						5/31/2022 Date/1110	3 9 13 am
Adj ustments col. 5.9's         Adj ustments col. 5.9's         Adj ustments           6.00         7.00         1.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE OSTS.         1.00           1.00         0         0         2.00           3.00         0         0         3.01           3.01         0         0         3.01           3.02         0         0         3.01           3.03         0         0         3.03           3.04         0         0         3.06           3.06         0         0         3.06           3.06         0         0         3.06           3.06         0         0         3.08           3.06         0         0         3.08           3.06         0         0         3.08           3.07         0         0         3.08           3.10         0         9         3.10           3.11         0         9         3.10           3.12         0         9         3.10           3.14         0         9         3.14           4.04 </td <td></td> <td>Net W</td> <td>/kst. A-7 Ref.</td> <td></td> <td></td> <td>0/01/2020</td> <td></td>		Net W	/kst. A-7 Ref.			0/01/2020	
i         i         i         i           6         00         7.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         2.00         3.00         0         1.00         2.00         3.01         3.01         3.01         3.02         3.02         3.03         3.03         3.03         3.03         3.04         0         0         3.05         3.05         3.06         3.07         3.08         0         0         3.09         3.06         3.06         3.06         3.06         3.07         3.10         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.11         3.111         3.11         3.11							
6.00         7.00           A. COSTS I NUMPER AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED         1.00           1.00         0         0         2.00           3.00         0         0         3.00         3.00           3.01         0         0         3.00         3.00           3.02         0         0         3.01         3.02           3.03         0         0         3.03         3.02           3.03         0         0         3.03         3.03           3.04         0         0         3.06         3.06           3.07         0         0         3.06         3.06           3.07         0         0         3.06         3.07           3.08         3.09         0         0         3.07           3.09         0         0         3.07         3.08           3.09         0         0         3.07         3.09           3.10         0         9         3.10         3.11           3.12         3.16         3.16         3.16         3.16           3.14         0         9         3.16         3.16<		(col. 4 minus					
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED           1.00         0         0         1.00         2.00         0         0         2.00         2.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.00         3.01         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.02         3.03         3.04         0         3.04         3.04         3.04         3.04         3.05         3.06         3		col. 5)*					
HOME OFFICE COSTS:         1.00         0		6.00	7.00				
				NTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR CLAIMED	
2.00         0         0         2.00         3.00         3.00           3.01         0         0         3.01         3.01         3.01           3.02         0         0         3.03         3.03         3.03           3.04         0         0         3.03         3.04         3.03           3.04         0         0         3.03         3.04         3.04           3.05         0         0         3.05         3.05         3.05           3.06         0         0         3.07         3.07         3.07           3.08         0         0         3.08         3.09         3.09           3.09         0         0         3.09         3.09         3.10           3.11         0         0         3.10         3.11         3.12           3.13         0         9         3.10         3.11         3.14           3.14         0         9         3.10         3.14         3.15           3.16         -83.250         0         4.00         4.00           4.01         681         9         4.02         4.02           4.03         991.356		HOME OFFICE COST	TS:				
3.00         0         0         3.00         3.00         3.00           3.01         0         0         3.01         3.02         3.03         3.03           3.03         0         0         3.03         3.03         3.04         3.04         3.04           3.05         0         0         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.04         3.05         3.04         3.04         3.05         3.04         3.04         3.05         3.06         3.07         3.07         3.07         3.07         3.09         3.10         3.11         3.112         3.13         3.14         3.14         3.14         3.14         3.14         3.14         3.14         3.14         3.14         3.14         3.14         3.14			-				
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3.16 $-83,250$ $0$ $3.16$ $4.00$ $3,260$ $9$ $4.00$ $4.01$ $681$ $9$ $4.01$ $4.02$ $232,850$ $0$ $4.02$ $4.03$ $991,356$ $0$ $4.03$ $4.04$ $78,333$ $9$ $4.04$ $4.05$ $164,509$ $9$ $4.06$ $3,061,981$ $0$ $4.07$ $-126,923$ $0$ $4.08$ $-3,370,691$ $0$ $4.09$ $-4,900$ $0$ $4.10$ $-88,575$ $0$ $4.11$ $-1,824,457$ $0$ $4.12$ $-353,830$ $0$ $4.13$ $-194,408$ $0$ $5.00$ $-1,514,064$ $5.00$			-				
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$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$			-				
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$							
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$			-				
4.07       -126,923       0       4.07         4.08       -3,370,691       0       4.08         4.09       -4,900       0       4.09         4.10       -88,575       0       4.10         4.11       -1,824,457       0       4.12         4.12       -353,830       0       4.13         5.00       -1,514,064       5.00       5.00			9				
4.08       -3,370,691       0       4.08         4.09       -4,900       0       4.09         4.10       -88,575       0       4.10         4.11       -1,824,457       0       4.11         4.12       -353,830       0       4.12         4.13       -194,408       0       4.13         5.00       -1,514,064       5.00			0				
4. 09       -4, 900       0         4. 10       -88, 575       0         4. 11       -1, 824, 457       0         4. 12       -353, 830       0         4. 13       -194, 408       0         5. 00       -1, 514, 064       5. 00			0				
4. 10       -88, 575       0       4. 10         4. 11       -1, 824, 457       0       4. 11         4. 12       -353, 830       0       4. 12         4. 13       -194, 408       0       4. 13         5. 00       -1, 514, 064       5. 00       5. 00			0				
4. 11       -1, 824, 457       0       4. 11         4. 12       -353, 830       0       4. 12         4. 13       -194, 408       0       4. 13         5. 00       -1, 514, 064       5. 00       5. 00			0				
4. 12       -353, 830       0         4. 13       -194, 408       0         5. 00       -1, 514, 064       5. 00			0				
4. 13       -194, 408       0         5. 00       -1, 514, 064       5. 00			0				
5. 00 -1, 514, 064 5. 00			Ű				
			0				
* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A. column 6. lines as	-						

\* 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.

nao no i			
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 HEALTHCARE	6.00
7.00 HEALTHCARE	7.00
8.00 HEALTHCARE	8.00
9.00	9.00
10. 00	10.00
100.00	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

	Financial Syste R BASED PHYSIC		UTHERAN MUSCULO		CCN: 15-0168	Peri od:	eu of Form CMS- Worksheet A-8	
						From 01/01/2022 To 12/31/2022		
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	1 00
1.00		ADMI NI STRATI VE & GENERAL	44, 340	29, 070	15, 27		83	
2.00 3.00	0.00	ANESTHESI OLOGY	335, 866				0	
4.00	0.00		0	-			0	
4.00 5.00	0.00		0				0	
6.00	0.00		0				0	
7.00	0.00		0	0			0	
8.00	0.00		0	0		0 0	0	
9.00	0.00		0		(	0 0	0	
10.00	0.00		0	0	(	0 0	0	
200.00			380, 206	364, 936	15, 27	D	83	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Education	12	11.00	
1.00	1.00	2.00 ADMINISTRATIVE & GENERAL	8.00	9.00	12.00	13.00 0 0	14.00 0	1.00
2.00		ADMINISTRATIVE & GENERAL ANESTHESI OLOGY	7, 143				0	
3.00	0.00	ANESTHESTOLOGI	0				0	
4.00	0.00		0				0	
5.00	0.00		0			0 0	0	
6.00	0.00		0		(		0	1
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	
200.00			7, 143			0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	0		8, 12			1.00
2.00	53.00	ANESTHESI OLOGY	0	0		335, 866		2.00
3.00	0.00		0	0	(	0 0		3.00
4.00	0.00		0	0	(	0 0		4.00
5.00	0.00		0		(			5.00
6.00	0.00		0	-	(			6.00
7.00	0.00		0	-		0 0		7.00
8.00	0.00		0			0 0		8.00
9.00	0.00		0	-		0 0		9.00
10.00 200.00	0.00		0		8, 12			10.00
	1	1	1 0	1 /. 143	ι <u>δ.</u> [2]	7 373,063		200.00

ST A	Financial Systems L LLOCATION - GENERAL SERVICE COSTS	UTHERAN MUSCULOS	Provi der CC	CN: 15-0168 P	eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part I	2002
		_		Т		Date/Time Pre 5/31/2023 9:1	
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation (from Wkst A			DEPARTMENT		
		col . 7)			4.00		
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	-
00	00100 CAP REL COSTS-BLDG & FIXT	4, 613, 697	4, 613, 697				1.0
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 040, 749 5, 272, 803	105, 543	7, 040, 749 161, 064	5, 539, 410		2.0 4.0
00	00500 ADMINI STRATI VE & GENERAL	15, 512, 497	0	0	1, 346, 121	16, 858, 618	
00	00700 OPERATION OF PLANT	2, 494, 228	781, 507	1, 192, 621	23, 824	4, 492, 180	
00 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	157, 392 532, 798	0	0	0 548	157, 392 533, 346	
	01000 DI ETARY	224, 530	0	0	0	224, 530	
. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	01300 NURSI NG ADMI NI STRATI ON	959, 049	0	0	227, 573	1, 186, 622	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 435, 164 414, 042	197, 767	301, 803	178, 967 71, 018	3, 113, 701 485, 060	14. 0 15. 0
	01600 MEDICAL RECORDS & LIBRARY	757, 418	0	0	6, 803	764, 221	16.0
	01700 SOCIAL SERVICE	0	0	0	0	0	17. (
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18.0
	02000 NURSING PROGRAM	0	0		0	0	19. 0 20. 0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	Ő	0	21.0
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.0
. 00	03000 ADULTS & PEDIATRICS	3, 530, 659	480, 945	733, 947	697, 281	5, 442, 832	30. (
	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.
	03200 CORONARY CARE UNIT	0	0	0	0	0	
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. ( 34. (
	04000 SUBPROVIDER - IPF	0	0	0	0	0	40.
	04100 SUBPROVIDER - IRF	0	0	0	0	0	41. (
	04300 NURSERY	0	0	0	0	0	43.0
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44.0
	04600 OTHER LONG TERM CARE	0	0	0	0	0	
~ ~	ANCI LLARY SERVI CE COST CENTERS	45 000 000	4 957 994		4 594 994		1 = 0
	05000 OPERATING ROOM 05100 RECOVERY ROOM	15, 989, 029 2, 572, 954	1, 057, 001 295, 711	1, 613, 041 451, 271	1, 534, 381 514, 521	20, 193, 452 3, 834, 457	50. 51.
	05200 DELIVERY ROOM & LABOR ROOM	2, 372, 934	2,3,711	431, 271	0	3, 034, 437	
	05300 ANESTHESI OLOGY	41, 709	0	0	0	41, 709	
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	652, 595	92, 112	140, 568	108, 429	993, 704	
	05500 RADI OLOGY-THERAPEUTI C	4, 403	0		0	4, 403	54. 55.
	05600 RADI OI SOTOPE	0	0	0	0	0	56.
	05700 CT SCAN	0	0	0	0	0	
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58. 59.
	06000 LABORATORY	461, 298	0	0	5, 837	467, 135	
	06001 BLOOD LABORATORY	0	0	0	0	0	60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	62. 63.
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.
	06500 RESPI RATORY THERAPY	34, 553	0	0	525	35, 078	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 609, 844	589, 965	900, 318	816, 556	5, 916, 683 0	66. 67.
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.
	06900 ELECTROCARDI OLOGY	60, 450	0	0	6, 704	67, 154	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	865, 962 20, 066, 443	0	0	0	865, 962 20, 066, 443	
	07300 DRUGS CHARGED TO PATIENTS	887, 517	0	0	0	887, 517	
. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77.
. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.
	09000 CLINIC 09100 EMERGENCY	0	0	0	0	0	
. 00		0	0	ı 0	0	0	1 01 1

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTER	ł	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I	pared:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS	-1					
94. 00         09400         HOME         PROGRAM         DI ALYSI S           95. 00         09500         AMBULANCE         SERVI CES           96. 00         09600         DURABLE         MEDI CAL         EQUI P-RENTED	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	94.00 95.00 96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSABLE COSTS	0	0		0 0	0	97.00 98.00
98.00 09900 CMHC	0	0			0	98.00
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	
102.00 OPI OI 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	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	114. 00 115. 00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	89, 191, 783	3, 600, 551	5, 494, 6	33 5, 539, 088		
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		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	16, 089	1, 013, 146	1, 546, 1			
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 SPORTS MEDI CI NE	3, 245, 555	0		0 0	3, 245, 555	
194.01 07951 SENIOR CIRCLE 200.00 Cross Foot Adjustments	0	0		0 0		194.01 200.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0		0		200.00
202.00 TOTAL (sum lines 118 through 201)	92, 453, 427	4, 613, 697	7, 040, 7	49 5, 539, 410		
· · · · · · · · · · · · · · · · · · ·						•

COST /	I Financial Systems L ALLOCATION - GENERAL SERVICE COSTS	UTHERAN MUSCULOS	Provider C	CN: 15-0168 P F	eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part I	
					o 12/31/2022	Date/Time Pre 5/31/2023 9:1	pared: 3 am
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	16, 858, 618	F 400 00F				5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 001, 815 35, 100	5, 493, 995 0				7.00
9.00	00900 HOUSEKEEPING	118, 943	0	192, 492			9.00
10.00	01000 DI ETARY	50, 073	0	0	002,207	274, 603	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	264, 632	0		0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	694, 396	291, 557		34, 616	0	14.00
15.00		108, 175	0	0	0	0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	170, 431	0		0	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0		0	0	18.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	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	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 213, 822	709, 031	158, 967	84, 182	274, 603	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 213, 022	07,031			274,005	31.00
32.00	03200 CORONARY CARE UNI T	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 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	0	0	0	0	41.00
43.00 44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0	0	43.00
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
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 503, 394	1, 558, 280			0	50.00
51.00	05100 RECOVERY ROOM	855, 134	435, 951	0		0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	9, 302	0		0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	221, 609	135, 796	-	16, 123	0	54.00
54.01	03630 ULTRA SOUND	982	0	0	0	0	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 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	58.00 59.00
60.00	06000 LABORATORY	104, 177	0		0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00		0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 823 1, 319, 497	0 869, 753		0 103, 264	0	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	1, 319, 497	007,753		103, 204	0	67.00
68.00		0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	14, 976	0	0	0	0	69.00
70.00		0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	193, 121	0	0	0	0	71.00
72.00		4, 475, 078	0	0	0	0	72.00
73.00 74.00		197, 928 0	0		0	0	73.00
75.00		0	0		0	0	74.00
77.00		0	0	0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			1
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00		0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	•
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			I			92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95.00		0	0	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
70.00		0		0	0	0	97.00

Health Financial Systems L	UTHERAN MUSCULO	SKELETAL CENTER	2	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	_	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	5.00	7.00	8.00	9.00	10.00	
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 OPIOLD 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 ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 560, 408	4, 000, 368	192, 49	92 474, 954	274, 603	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	574, 409	1, 493, 627		0 177, 335		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194. 00 07950 SPORTS MEDI CI NE	723, 801	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	16, 858, 618	5, 493, 995	192, 49	652, 289	274, 603	202.00

	Financial Systems L LLOCATION - GENERAL SERVICE COSTS	UTHERAN MUSCUL	DSKELETAL CENTER Provider CC		Peri od:	Worksheet B	2552-10
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/31/2023 9:1	pared: 3 am
	Cost Center Description	MAINTENANCE O PERSONNEL	F NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		12.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL		0				12.00
13.00	01300 NURSING ADMINISTRATION		0 1, 451, 254				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY			4, 134, 27 15, 92			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		0 0	15, 72	0 0 0	934, 652	
	01700 SOCIAL SERVICE		0 0		0 0	0	17.00
	01850 OTHER GENERAL SERVICES		0 0		0 0	0	
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM				0 0	0	
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV				0 0	0	•
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0 0		0 0	0	•
23.00	02300 PARAMED ED PRGM		0 0		0 0	0	23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		0 447, 293	33, 22	.1 0	14, 338	30.00
30.00	03100 I NTENSI VE CARE UNI T		0 447, 293	33, 22	0 0	14, 336	1
32.00	03200 CORONARY CARE UNI T		0 0		0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT		0 0		0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T		0 0		0 0	0	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF				0 0	0	
41.00	04300 NURSERY				0 0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY		0 0		0 0	0	•
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	ANCI LLARY SERVI CE COST CENTERS		0 642, 288	1, 126, 75	1 0	293, 553	50.00
51.00	05100 RECOVERY ROOM		0 360, 750	.,, .	0 0	59, 239	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0 0		0 0	0	52.00
53.00			0 0	4, 67		27,031	1
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND		0 89		0 0	23, 255 35	1
55.00	05500 RADI OLOGY-THERAPEUTI C		0 0		0 0	0	•
56.00	05600 RADI OI SOTOPE		0 0		0 0	0	
	05700 CT SCAN		0 0		0 0	0	
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON				0 0	0	
60.00	06000 LABORATORY		0 425	8, 46	8 0	12, 389	
	06001 BLOOD LABORATORY		0 0	-,	0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0	0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY				0 0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY		o 0		o o	681	•
66.00	06600 PHYSI CAL THERAPY		0 0	16, 82	3 0	44, 015	•
	06700 OCCUPATIONAL THERAPY		0 0		0 0	0	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0 0 0 409		0 0	0 2 210	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY		0 0		0 0	2,210	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0 0	94, 90	02 0	60, 214	
	07200 I MPL. DEV. CHARGED TO PATIENTS		0 0	2, 714, 27		354, 063	•
	07300 DRUGS CHARGED TO PATIENTS		0 0	119, 05	0 609, 160	43, 546	•
74.00 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)					83	•
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0 0		0 0	0	•
00.55	OUTPATIENT SERVICE COST CENTERS						0.0.0
88.00	08800 RURAL HEALTH CLINIC		0 0		0 0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					0	
	09100 EMERGENCY		o 0		0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S		0 0		0 0	0	
	09500 AMBULANCE SERVICES		0 0		0 0	0	95.00

Health Financial Systems LL	JTHERAN MUSCULOS	KELETAL CENTER		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022		
Cost Center Description	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
	10.00	10.00	SUPPLY	15.00	LIBRARY	
	12.00	13.00	14.00	15.00	16.00	07.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	
98. 00 09850 OTHER REI MBURSABLE COSTS	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
102. 00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISTITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0				108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		1109.00
	0	0		0 0		
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 451, 254	4, 134, 09	609, 160	934, 652	118.00
						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	18	0 0		192.00
193. 00 19300 NONPAI D 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	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00  TOTAL (sum lines 118 through 201)	0	1, 451, 254	4, 134, 27	609, 160	934, 652	202.00

ST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2022	Worksheet B Part I	
				Ť		Date/Time Pre 5/31/2023 9:1	epared
			OTHER GENERAL			INTERNS &	
			SERVI CE			RESI DENTS	<u> </u>
	Cost Center Description	SOCI AL SERVI CE	S	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	
				7		APPRV	
	OFNEDAL OFDIVLOF ODOT OFNITEDO	17.00	18.00	19.00	20.00	21.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.
00	00200 CAP REL COSTS-MVBLE EQUIP						2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00 00	00500 ADMI NI STRATI VE & GENERAL						5.
00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.
00	00900 HOUSEKEEPI NG						9.
00	01000 DI ETARY						10.
00	01200 MAINTENANCE OF PERSONNEL						12.
. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.
00	01500 PHARMACY						15.
. 00	01600 MEDI CAL RECORDS & LI BRARY		- 				16.
00	01700 SOCIAL SERVICE	0					17
. 00	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS	0		0			18
00	02000 NURSI NG PROGRAM	0		0	0		20
00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C	)	_	0	
00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C				22
00	02300 PARAMED ED PRGM	0	C				23
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	C	0	0	0	30
00	03100 I NTENSI VE CARE UNI T	0	C		0	0	
00	03200 CORONARY CARE UNIT	0	C	0	0	0	32
00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	
00 00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0		-	0	0	
00	04100 SUBPROVIDER - IRF	0		0	0	0	
00	04300 NURSERY	0	C	0	0	0	
. 00	04400 SKI LLED NURSI NG FACI LI TY	0	C	0	0	0	
. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0	0	
. 00	ANCI LLARY SERVICE COST CENTERS	0		0	0	0	40
. 00	05000 OPERATING ROOM	0	C	0	0	0	50
00	05100 RECOVERY ROOM	0	C	0	0	0	
00 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0		0	0	0	
00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0	0	1
01	03630 ULTRA SOUND	0	C	0	0	0	
	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	
	05600 RADI OI SOTOPE	0	C	0	0	0	
00 00	05700 CT SCAN 05800 MRI	0		0	0	0	
	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	
00	06000 LABORATORY	0	C	0	0	0	60
01	06001 BLOOD LABORATORY	0	C	0	0	0	
00 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C C	0	0	0	61 62
	06300 BLOOD STORING, PROCESSING & TRANS.	0	l c	0	0	0	
00	06400 I NTRAVENOUS THERAPY	0	C	0	0	0	1
	06500 RESPI RATORY THERAPY	0	C	0	0	0	
00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0		0	0	0	
	06800 SPEECH PATHOLOGY	0		0	0	0	
	06900 ELECTROCARDI OLOGY	0	C	0	0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0	0	0	
	07400 RENAL DIALYSIS	0		0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	C	0	Ő	0	
00	07700 ALLOGENEIC HSCT ACQUISITION	0	C	0	0	0	77
00	OUTPATIENT SERVICE COST CENTERS		^			^	0.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
	09000 CLINIC	0		0	0	0	
00	09100 EMERGENCY	0	C	0	Ő	0	
~ ~	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
00	OTHER REIMBURSABLE COST CENTERS				l		

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	R	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		OTHER GENERAL SERVI CE			5/31/2023 9:1 I NTERNS & RESI DENTS	
Cost Center Description	SOCI AL SERVI CE	S	NONPHYSI CI A ANESTHETI ST		SERVI CES-SALAR Y & FRI NGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
95.00 09500 AMBULANCE SERVI CES	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		101.00
102.00 10200 OPI OLD 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		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	0	118.00
NONREI MBURSABLE COST CENTERS					i	_
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194. 00 07950 SPORTS MEDI CI NE	0	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0		194. 01
200.00 Cross Foot Adjustments				0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 0	0	202.00

NTER			In Lie	u of Form CMS-	2552-10	
r CCN: 15-0168		Period:		Worksheet B		
			rom 01/01/2022	Part I		
		T	o 12/31/2022	Date/lime Pre		
				5/31/2023 9:1	3 am	
ED	Subtotal		Intern & Residents Cost	Total		

				_		5/31/2023 9:1	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM		Intern & Residents Cost & Post Stepdown Adjustments		
		22.00	23.00	24.00	25.00	26.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	GENERAL       SERVICE       COST CENTERS         00100       CAP       REL       COSTS-BLDG & FIXT         00200       CAP       REL       COSTS-BVBLE       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         01400       CENTRAL       SERVICES       & SUPPLY         01500       PHARMACY       01600       MEDICAL       RECORDS       & LI BRARY         01700       SOCIAL       SERVICE       01900       NONPHYSICIAN       ANESTHETISTS         02000       NURSING PROGRAM       O2000       NURSING PROGRAM       O2100       I&R SERVICES-SALARY       & FRINGES       APPRV						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300 PARAMED ED PRGM						23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	8, 378, 289	0	8, 378, 289	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C	0 0,070,207	0	0,070,207	
32.00	03200 CORONARY CARE UNI T	0	C	0 0	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	(		0	0	
40.00	04100 SUBPROVIDER - IRF	0	(		0	0	1
43.00	04300 NURSERY	0	C	0 0	0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	(		0	0	
10.00	ANCI LLARY SERVICE COST CENTERS			<u> </u>	0		10.00
50.00	05000 OPERATING ROOM	0	C		0		
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	5, 597, 290	0	5, 597, 290 0	
52.00	05300 ANESTHESI OLOGY	0	C	82,718	0	82, 718	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	1, 390, 576	0	1, 390, 576	1
54.01	03630 ULTRA SOUND	0	(	5, 420	0	5, 420	1
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0	0	1
57.00	05700 CT SCAN	0	0		0	0	1
58.00	05800 MRI	0	C	0 0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	ĺ	592, 594	0	592, 594 0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0 0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	(	43, 582	0	0 43, 582	
66.00	06600 PHYSI CAL THERAPY	0	(	8, 270, 035	0	8, 270, 035	1
67.00	06700 OCCUPATI ONAL THERAPY	0	C	0 0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0	0	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	(	84,749	0	84, 749 0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(	1, 214, 199	0	1, 214, 199	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	27, 609, 858	0	27, 609, 858	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	1, 857, 201	0	1, 857, 201	
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	(	) 83 ) 0	0	83 0	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	1
00.00					2		00.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	( (	0 lr		0	
90.00	09000 CLINIC	0	0		0	0	
91.00	09100 EMERGENCY	0	C	0 0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0	1	92.00

In Lieu of Form CMS-2552-10							
CN: 15-0168	Period: From 01/01, To 12/31,	/2022 Part I /2022 Date/Tim					
Subtotal	Intern	8 Total					

					<u>5/31/2023 9:1</u>	<u>3 am</u>
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
				Adjustments		
	22.00	23.00	24.00	25.00	26.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
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 C	0	97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0	(	0 0	0	98.00
99.00 09900 CMHC	0	0	(	o c	0	99.00
99. 10 09910 CORF	0	0	(	o o	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(	o o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	(	o o	0	101.00
102.00 10200 OPI OLD TREATMENT PROGRAM	0	0	(	o o	0	102.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(	o o	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	(	o o	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	(	o o	0	108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	(	o o	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(	o o	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(	0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		o o	0	115.00
116. 00 11600 HOSPI CE	_	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	83, 662, 84	7 0	83, 662, 847	
NONREI MBURSABLE COST CENTERS	-1			·		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	4, 821, 22	4 0	4, 821, 224	
193. 00 19300 NONPALD WORKERS	0	0	1,021,22			193.00
194. 00 07950 SPORTS MEDI CI NE	0	0	3, 969, 35	6 0	3, 969, 356	
194. 01 07951 SENI OR CI RCLE	0	0	0,707,00			194.01
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers	0	0				200.00
202.00 TOTAL (sum Lines 118 through 201)	0	0	92, 453, 42	7 0	92, 453, 427	
	, oj	0	1 ,2,100,42	-i ol	72, 100, 427	202.00

ALLOCA	Financial Systems LL TION OF CAPITAL RELATED COSTS	JTHERAN MUSCULOS	Provider CC	CN: 15-0168 P F	eriod: rom 01/01/2022 o 12/31/2022	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/31/2023 9:1	pared:
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		105 510			o	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	105, 543	161, 064	266, 607	266, 607	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	0 781, 507	1, 192, 621	0 1, 974, 128	64, 788 1, 147	5.00 7.00
3.00 3.00	00800 LAUNDRY & LINEN SERVICE	0	/81, 50/	1, 192, 021	1, 774, 120	1, 147	
9.00	00900 HOUSEKEEPING	0	0	0	0	26	
10.00	01000 DI ETARY	0	0	0	0	0	1
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	10, 953	
	01400 CENTRAL SERVICES & SUPPLY	0	197, 767	301, 803	499, 570	8,614	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	0		0	3, 418 327	
	01700 SOCIAL SERVICE	0	0	0	0	0	
	01850 OTHER GENERAL SERVICES	0	0	0	0	0	1
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	02000 NURSI NG PROGRAM	0	0	0	0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	480, 945	733, 947	1, 214, 892	33, 560	30.00
	03100 I NTENSI VE CARE UNI T	0	0	0	0	00,000	31.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
	04000 SUBPROVIDER - IPF	0	0	0	0	0	
	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0		0	0	41.00 43.00
	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	44.00
	04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
-0.00	ANCI LLARY SERVICE COST CENTERS		4 057 004	1 (10 011	0 (70 040	70.04/	50.00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	1, 057, 001 295, 711	1, 613, 041		73, 846 24, 764	
	05200 DELIVERY ROOM & LABOR ROOM	0	293, 711	451, 271	140, 902	24, 784	
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	92, 112	140, 568	232, 680	5, 219	54.00
54.01	03630 ULTRA SOUND	0	0	0	0	0	54.01
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
	05600 RADI OI SOTOPE	0	0	0	0	0	
	05700 CT SCAN 05800 MRI	0	0		0	0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
	06000 LABORATORY	0	0	0	0	281	
	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0			25	
	06600 PHYSI CAL THERAPY	0	589, 965	900, 318	1, 490, 283	39, 300	
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0,000	
	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	0	0	0	0	323	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0		0	0	
	07400 RENAL DIALYSIS		0			0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	1
74.00		0	0	0	0	0	
74.00 75.00	07700 ALLOGENEIC HSCT ACQUISITION	0					
74.00 75.00		0					
74.00 75.00 77.00 38.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0	0	
74.00 75.00 77.00 38.00 39.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89.00
74.00 75.00 77.00 38.00 39.00 90.00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		000000000000000000000000000000000000000	000000000000000000000000000000000000000			89.00 90.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/31/2023 9:1	epared: 3 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
OTHER REIMBURSABLE COST CENTERS			1			
94. 0009400HOMEPROGRAMDI ALYSI S95. 0009500AMBULANCESERVI CES96. 0009600DURABLEMEDI CALEQUI P-RENTED97. 0009700DURABLEMEDI CALEQUI P-SOLD		0 0 0				95.00 96.00
98. 00 09850 OTHER REIMBURSABLE COSTS 99. 00 09900 CMHC		0				98.00 99.00
99. 10 09910 CORF 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY		0			C	100. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0		0 0	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	C	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	C	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	C	111.00
113.0011300INTEREST 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 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0 3, 600, 551	5, 494, 6	0 0 33 9, 095, 184		116.00
NONREIMBURSABLE COST CENTERS	0	3, 000, 551	5, 494, 6,	9,095,184	266, 591	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 013, 146	1, 546, 1			192.00
193.00 19300 NONPALD WORKERS	0	0	,	0 0		193.00
194.00 07950 SPORTS MEDICINE	0	0		0 0	C	194.00
194.01 07951 SENI OR CI RCLE	0	0		0 0	C	194.01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	4, 613, 697	7, 040, 7	11, 654, 446	266, 607	202.00

	Financial Systems LI TION OF CAPITAL RELATED COSTS	JTHERAN MUSCULOS	FINDER FOR SKELETAL CENTER	CN: 15-0168 P	<u>In Lie</u> eriod: rom 01/01/2022	u of Form CMS-: Worksheet B Part II	2552-10
				T		Date/Time Pre 5/31/2023 9:1	
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LI NEN SERVI CE 8. 00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	71.00	10100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	64, 788					5.00
7.00	00700 OPERATION OF PLANT	3, 850	1, 979, 125				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	135 457	0	135 0			8.00 9.00
7.00 10.00	01000 DI ETARY	192	0	0	485	192	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1,017	0		0	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2, 668 416	105, 029 0	0	26 0	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LI BRARY	655	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0	0	0	0	18.00
19.00 20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0	0	0	19.00 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 I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	4, 665	255, 417	111	62	192	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0			0	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00 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 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	43.00 44.00
45.00	04500 NURSI NG FACI LI TY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	17, 308	561, 345	24	138	0	50.00
51.00	05100 RECOVERY ROOM	3, 286	157, 045			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	36 852	0 48, 918	0	0 12	0	53.00 54.00
54.00	03630 ULTRA SOUND	4	40, 910	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00 57.00
	05700 CT SCAN 05800 MRI	0	0	0	0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	400	0	0	0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 30	0	0	0	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	5,071	313, 315	0	76	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68.00
69.00 70.00	07000 ELECTROENCEPHALOGRAPHY	58	0	0	0	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	742	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	17, 197	0	0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	761	0	0	0	0	73.00 74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
00 00	OUTPATIENT SERVICE COST CENTERS					^	00 00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00 89.00
90.00	09000 CLI NI C	0	0	0	o	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			1			92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 97.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	96.00 97.00
//.00	UST SOLDONADEL MEDIONE LUUII-SULD	U U	0	ı 0	U U	0	1 //.00

Health Financial Systems	JTHERAN MUSCULOS	SKELETAL CENTER	R	In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 9:1	pared: <u>3 am</u>
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICI	HOUSEKEEPI NG	DI ETARY	
	5.00	7.00	8.00	9.00	10.00	
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 OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	59, 800	1, 441, 069	13	5 352	192	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 PHYSI CLANS' PRI VATE OFFI CES	2, 207	538, 056		0 131		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194. 00 07950 SPORTS MEDICINE	2, 781	0		0 0		194.00
194. 01 07951 SENI OR CI RCLE	0	0		0 0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	64, 788	1, 979, 125	13	5 483	192	202.00

Heal th	Financial Systems	UTHERAN MUSCUL	OSKELETAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	:N: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/31/2023 9:1	pared:
	Cost Center Description	MAINTENANCE O PERSONNEL	F NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		12.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1,00
2.00	00200 CAP REL COSTS-BEDG & TTXT						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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
12.00	01200 MAINTENANCE OF PERSONNEL		0				12.00
13.00	01300 NURSING ADMINISTRATION		0 11, 970				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		0 0	615, 90		- -	14.00
	01500 PHARMACY		0 0	2, 37			15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				0 0	982	1
	01850 OTHER GENERAL SERVICES				0 0	0	
	01900 NONPHYSI CI AN ANESTHETI STS		0 0		0 0	0	1
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	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0 0		0 0	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0 0		0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS		0 3, 688	4, 94	9 0	15	30.00
31.00	03100 INTENSIVE CARE UNIT		0 0		0 0	0	1
	03200 CORONARY CARE UNI T		0 0		0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0 0		0 0	0	
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0 0		0 0	0	
40.00	04100 SUBPROVIDER - IRF					0	
43.00	04300 NURSERY		0 0		0 0	0	
	04400 SKILLED NURSING FACILITY		0 0		0 0	0	1
45.00	04500 NURSING FACILITY		0 0		0 0	0	
46.00	04600 OTHER LONG TERM CARE		0 0		0 0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS		0 5, 299	167, 85	6 0	297	50.00
50.00	05100 RECOVERY ROOM		0 2,975	107, 00	0 0	60	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0 0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY		0 0	69	7 0	27	1
54.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND		0 1		0 0	24	1
54. 01 55. 00	05500 RADI OLOGY-THERAPEUTI C					0	
56.00	05600 RADI OI SOTOPE		0 0		0 0	0	1
57.00	05700 CT SCAN		0 0		0 0	0	57.00
	05800 MRI		0 0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON		0 0	1 0/	0 0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY			1, 26	0 0	13	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ŭ Ŭ		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0 0		0 0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0 0		0 0	0	
	06400 I NTRAVENOUS THERAPY				0 0	0	64.00 65.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			2, 50		1 45	1
	06700 OCCUPATI ONAL THERAPY		o ol	2, 50	o o	0	
	06800 SPEECH PATHOLOGY		0 0		0 0	0	1
	06900 ELECTROCARDI OLOGY		0 3		0 0	2	
	07000 ELECTROENCEPHALOGRAPHY		0 0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			14, 13 404, 36		61 393	
	07300 DRUGS CHARGED TO PATIENTS			404, 30		44	1
	07400 RENAL DI ALYSI S	1	o o	.,,,,	0 0	0	1
75.00	07500 ASC (NON-DI STI NCT PART)		0 0		0 0	0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0 0		0 0	0	77.00
88.00	OUTPATIENT SERVICE COST CENTERS					0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	
	09000 CLINIC	]	0 0		0 0	0	
91.00	09100 EMERGENCY		0 0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S					0	94.00
	09500 AMBULANCE SERVICES				0 0	0	
	09600 DURABLE MEDI CAL EQUI P-RENTED	1	0 0		0 0	0	
	· · · ·		, -1		1		

Health Financial Systems LL	JTHERAN MUSCULOS	KELETAL CENTER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	5/31/2023 9:1	
Cost Center Description	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
	FLKJUNNEL		SUPPLY		LIBRARY	
	12.00	13.00	14.00	15.00	16.00	
97.00 09700 DURABLE MEDI CAL EQUI P-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 OI D TREATMENT PROGRAM	0	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 ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0	(45.00	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	11, 970	615, 88	6, 206	982	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		7 0		191.00
193. 00 19300 NONPALD WORKERS	0	0	2	0 0		193.00
194. 00 07950 SPORTS MEDI CI NE	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	Ű		-	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	11, 970	615, 90	6, 206		202.00

	ial Systems I CAPITAL RELATED COSTS	LUTHERAN MUSCULOS		CN: 15-0168 F	Peri od:	eu of Form CMS- Worksheet B	
					rom 01/01/202 o 12/31/202		pared
					1	5/31/2023 9:1	3 am
			OTHER GENERAL SERVI CE			I NTERNS & RESI DENTS	
(	Cost Center Description	SOCI AL SERVI CE	S	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	
				ANESTHETI STS	PROGRAM	Y & FRINGES	
		17.00	10.00	10.00	20,00	APPRV	<u> </u>
GENERAL	_ SERVICE COST CENTERS	17.00	18.00	19.00	20.00	21.00	-
	CAP REL COSTS-BLDG & FIXT						1.0
	CAP REL COSTS-MVBLE EQUIP						2.0
00 00400 E	MPLOYEE BENEFITS DEPARTMENT						4. (
	ADMINISTRATIVE & GENERAL						5.0
	DPERATION OF PLANT						7.0
	AUNDRY & LINEN SERVICE						8.0
00 00900 H 0.00 01000 E	IOUSEKEEPI NG						9. 10.
	IAINTENANCE OF PERSONNEL						12.
	IURSI NG ADMI NI STRATI ON						13.
. 00 01400 0	CENTRAL SERVICES & SUPPLY						14.
	PHARMACY						15.
	IEDI CAL RECORDS & LI BRARY						16.
	SOCIAL SERVICE	0					17.
	OTHER GENERAL SERVICES	0	(				18.
	IONPHYSI CI AN ANESTHETI STS IURSI NG PROGRAM	0	(	-		0	20.
	&R SERVICES-SALARY & FRINGES APPRV	0	(			0	
	&R SERVICES-OTHER PRGM COSTS APPRV	0	(			_	22.
	PARAMED ED PRGM	0	(				23.
	ENT ROUTINE SERVICE COST CENTERS			1		1	
	ADULTS & PEDIATRICS	0	(	1			30.
	NTENSIVE CARE UNIT	0	(	1			31.
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(				32.
	SURGICAL INTENSIVE CARE UNIT	0	(				34.
	SUBPROVIDER - IPF	0	(				40.
	SUBPROVIDER - IRF	0	C				41.
8.00 04300 M	IURSERY	0	(				43.
	SKILLED NURSING FACILITY	0	(				44.
	IURSING FACILITY	0	(				45.
	OTHER LONG TERM CARE	0	(	<u>)</u>			46.
	DERATING ROOM	0	(				50.
	RECOVERY ROOM	0	(				51.
	DELIVERY ROOM & LABOR ROOM	0	(				52.
	NESTHESI OLOGY	0	(				53.
	RADI OLOGY-DI AGNOSTI C	0	(				54.
	JLTRA SOUND	0	(	)			54.
	RADI OLOGY-THERAPEUTI C	0	(				55
. 00 05700 0	RADI OI SOTOPE	0	(				56
. 00 05800 M		0	(				58
	CARDI AC CATHETERI ZATI ON	0	(				59
1 1	ABORATORY	0	(				60
1 1	LOOD LABORATORY	0	(	D			60
	PBP CLINICAL LAB SERVICES-PRGM ONLY						61
	WHOLE BLOOD & PACKED RED BLOOD CELL	0	(	0			62.
	BLOOD STORING, PROCESSING & TRANS.	0	(				63 64
	NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	(				65
	PHYSICAL THERAPY	0	(				66
	DCCUPATIONAL THERAPY	0	(		1		67
	SPEECH PATHOLOGY	0	(	D			68
	LECTROCARDI OLOGY	0	(				69
		0	(				70
	IEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	(	2			71
	MPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	(	, ,			72.
	RENAL DIALYSIS	0	(				74.
	ASC (NON-DISTINCT PART)	0	(				75.
	ALLOGENEIC HSCT ACQUISITION	0	(				77.
	ENT SERVICE COST CENTERS						1
. 00 08800 F	RURAL HEALTH CLINIC	0	(	)			88.
	EDERALLY QUALIFIED HEALTH CENTER	0	(				89.
0.00 09000 0		0	(				90.
.00 09100 E .00 09200 0		0	(	י 			91. 92.
	DBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS			I	<u> </u>		1 72.
UTHER 1	LI MEDICONDEL COOT CENTENS						4

Health Financial Systems LU	THERAN MUSCULOS	KELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/31/2023 9:1	epared:
Cont Contra Description	SOCI AL SERVI CE	OTHER GENERAL SERVICE		N NURSI NG	I NTERNS & RESI DENTS SERVI CES-SALAR	
Cost Center Description	SUCTAL SERVICE	S	NONPHYSI CI A ANESTHETI ST		Y & FRI NGES APPRV	
	17.00	18.00	19.00	20.00	21.00	
95.00 09500 AMBULANCE SERVICES	0	0				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0				97.00
98.00 09850 OTHER REIMBURSABLE COSTS	0	0				98.00
99. 00 09900 CMHC	0	0				99.00
99. 10 09910 CORF	0	0				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
102.00 10200 OPI OLD TREATMENT PROGRAM	0	0				102.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0	I			105.00
106.00 10600 HEART ACQUI SI TI ON	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0				108.00
109.00 10900 PANCREAS ACQUISITION	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116.00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 0	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
194.0007950 SPORTS MEDICINE	0	0				194.00
194. 01 07951 SENI OR CI RCLE	0	0				194. 01
200.00 Cross Foot Adjustments				0 0	C	200.00
201.00 Negative Cost Centers	0	0		0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 0	0	202.00

		UTHERAN MUSCULOS				u of Form CMS-2	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2022	Worksheet B Part II	
				T	0 12/31/2022	Date/Time Pre 5/31/2023 9:1	
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post	Total	
					Stepdown		
		22.00	23.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS						1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
	01000 DI ETARY						10.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01850 OTHER GENERAL SERVICES 01900 NONPHYSICIAN ANESTHETISTS						18.00 19.00
	02000 NURSI NG PROGRAM						20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV						21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS		C				23.00
30.00	03000 ADULTS & PEDIATRICS			1, 517, 551	0	1, 517, 551	30.00
	03100 I NTENSI VE CARE UNI T			0	-	0	
	03200 CORONARY CARE UNIT			0	0	0	
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				0	0	
	04000 SUBPROVI DER – I PF			0	0	0	1
	04100 SUBPROVI DER – I RF			0	0	0	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY			0	0	0	43.00
	04500 NURSING FACILITY			0	-	0	1
46.00	04600 OTHER LONG TERM CARE			0	0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	1		3, 496, 155	0	3, 496, 155	50.00
	05100 RECOVERY ROOM			935, 150		935, 150	
	05200 DELIVERY ROOM & LABOR ROOM			0	0	0	
	05300 ANESTHESI OLOGY			760		760 287, 706	53.00
	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND			287, 706	0	287,708	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C			0	0	0	55.00
	05600 RADI OI SOTOPE			0	0	0	56.00
	05700 CT SCAN 05800 MRI				0	0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON			0	0	0	1
	06000 LABORATORY			1, 960	0	1, 960	
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0	0	0	60.01 61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.			0	0	0	
	06400 INTRAVENOUS THERAPY			0	0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			56 1, 850, 596	0	56 1, 850, 596	1
	06700 OCCUPATI ONAL THERAPY			0	0	0	
	06800 SPEECH PATHOLOGY			0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			386	0	386 0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			14, 941	0	14, 941	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			421, 955		421, 955	72.00
	07300 DRUGS CHARGED TO PATIENTS			24, 746	0	24, 746	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)			0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION				-	0	1
	OUTPATIENT SERVICE COST CENTERS	· ·		1			
	08800 RURAL HEALTH CLINIC			0	-	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	
	09000 CLINIC						
90. 00 91. 00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART			0	0	0	1

Health Financial Systems L	UTHERAN MUSCULOS	KELETAL CENTER	२	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/31/2023 9:1	pared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	22.00	23.00	24.00	25.00	26.00	
OTHER REIMBURSABLE COST CENTERS			_			
94. 0009400HOMEPROGRAMDI ALYSI S95. 0009500AMBULANCESERVI CES96. 0009600DURABLEMEDI CALEQUI P-RENTED				0 0 0 0 0 0	0 0 0	94.00 95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COSTS 99. 00 09900 CMHC				0 0 0 0 0 0	0 0 0	97.00 98.00 99.00
99.10 09910 CORF 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY				0 0 0 0 0 0	0	99. 10 100. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM				0 0	0	102.00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON			1	0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON				0 0		106.00
107.00 10700 LIVER ACQUISITION				0 0		107.00
108.00 10800 LUNG ACQUISITION				0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION				0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION				0 0		110. 00
111.00 11100 I SLET ACQUI SI TI ON				0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF				0 0	0	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				0 0		115.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	8, 551, 9	66 0	8, 551, 966	
NONREI MBURSABLE COST CENTERS	<u> </u>		0,001,7	00 0	0,001,700	110.00
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			3, 099, 6	99 0	3, 099, 699	192.00
193. 00 19300 NONPALD WORKERS				0 0	0	193.00
194. 00 07950 SPORTS MEDI CI NE			2, 7	81 0	2, 781	194.00
194. 01 07951 SENI OR CI RCLE				0 0	-	194.01
200.00 Cross Foot Adjustments	0	0		0 0	-	200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00  TOTAL (sum lines 118 through 201)	0	0	11, 654, 4	46 0	11, 654, 446	202.00

General Service Cost Center Description         CAPITAL RELATED COSTS         Reconciliation         ADMINISTR, & GENERAL           1.00         2.00         4.00         5A         5.00           00100         CAP REL COSTS - BLDG & FIXT         164, 539         64, 539         64, 539           2.00         00200         CAP REL COSTS - MVBLE EQUIP         164, 539         164, 539         164, 539           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         3, 764         3, 764         20, 907, 215           5.00         00500         ADMINISTRATIVE & GENERAL         0         0         5, 080, 622         -16, 858, 618         75, 59           7.00         00700         OPERATION OF PLANT         27, 871         27, 871         89, 917         0         4, 49           9.00         00900         HOUSEKEEPING         0         0         0         0         15	AL
Cost Center Description         BLDG & FIXT (SOUARE FEET)         MVBLE EQUIP (SOUARE FEET)         EMPLOYEE (SOUARE FEET)         Reconciliation (GROSS SALARIES)         ADMINISTRA- (ACCUM. CO SALARIES)           1.00         00100         CAP REL COST CENTERS         1.00         2.00         4.00         5A         5.00           1.00         00100         CAP REL COSTS-BLDG & FIXT         164, 539 </td <td>ATI VE AL</td>	ATI VE AL
GENERAL SERVICE COST CENTERS         Image: Cost of the service cost centers         Servicenters         Service cost centers	AL
I. 00         2. 00         4. 00         5A         5. 00           GENERAL SERVICE COST CENTERS         I. 00         0.0100         CAP REL COSTS-BLDG & FIXT         164, 539         1.64, 539         I. 64, 539	
1.00       00100       CAP       REL       COSTS-BLDG & FIXT       164,539         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT       3,764       3,764       20,907,215         5.00       00500       ADMINISTRATIVE       & GENERAL       0       0       5,080,622       -16,858,618       75,59         7.00       00700       OPERATION OF PLANT       27,871       27,871       89,917       0       4,493         8.00       00800       LAUNDRY & LINEN SERVICE       0       0       0       15         9.00       00900       HOUSEKEEPING       0       0       2,069       0       533	
2.00         00200         CAP_REL_COSTS-MVBLE_EQUIP         164, 539           4.00         00400         EMPLOYEE_BENEFITS_DEPARTMENT         3, 764         3, 764         20, 907, 215           5.00         00500         ADMI NI STRATI VE & GENERAL         0         0         5, 080, 622         -16, 858, 618         75, 59-           7.00         00700         OPERATION OF PLANT         27, 871         27, 871         89, 917         0         4, 49:           8.00         00800         LAUNDRY & LI NEN SERVICE         0         0         0         15:           9.00         00900         HOUSEKEEPI NG         0         0         27, 873         27, 874         20, 907, 215	
4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT         3, 764         3, 764         20, 907, 215           5.00         00500         ADMINISTRATIVE & GENERAL         0         0         5, 080, 622         -16, 858, 618         75, 594           7.00         00700         OPERATION OF PLANT         27, 871         27, 871         89, 917         0         4, 492           8.00         00800         LAUNDRY & LINEN SERVICE         0         0         0         15           9.00         00900         HOUSEKEEPING         0         0         0         533	1.00
5.00         00500         ADMI NI STRATI VE & GENERAL         0         5,080,622         -16,858,618         75,59           7.00         00700         OPERATI ON OF PLANT         27,871         27,871         89,917         0         4,499           8.00         00800         LAUNDRY & LI NEN SERVICE         0         0         0         15           9.00         00900         HOUSEKEEPI NG         0         0         0         533	4.00
8.00         00800         LAUNDRY & LINEN SERVICE         0         0         0         15'           9.00         00900         HOUSEKEEPING         0         0         2,069         0         53'	
9. 00 00900 HOUSEKEEPI NG 0 0 2, 069 0 533	2, 180 7. 00
	7, 392 8.00
10.00 01000 DI ETARY 0 0 0 0 22-	3, 346 9. 00 4, 530 10. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0	0 12.00
	6, 622 13. 00
	3, 701 14.00
	5, 060 15. 00 4, 221 16. 00
17. 00 01700 SOCIAL SERVICE 0 0 0 0	0 17.00
18.00 01850 OTHER GENERAL SERVICES 0 0 0 0	0 18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0	0 19.00
20.00         02000         NURSI NG         PROGRAM         0         0         0         0           21.00         02100         I & & SERVI CES-SALARY & FRI NGES APPRV         0         0         0         0         0	0 20.00 0 21.00
22. 00 02200 I &R SERVICES-SALARY & PRINCES APPRV 0 0 0 0 0	0 22.00
23. 00 02300 PARAMED ED PRGM 0 0 0 0	0 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00         03000         ADULTS & PEDIATRICS         17, 152         17, 152         2, 631, 727         0         5, 44:           31. 00         03100         INTENSIVE CARE UNIT         0         0         0         0	2,832 30.00
32. 00 03200 CORONARY CARE UNIT 0 0 0 0	0 31.00 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 UNIT 0 0 0 0	0 34.00
40.00 04000 SUBPROVIDER - I PF 0 0 0 0	0 40.00
41.00         04100         SUBPROVI DER - I RF         0         0         0         0           43.00         04300         NURSERY         0         0         0         0         0	0 41.00 0 43.00
43. 00 04400 SKI LLED NURSING FACILITY 0 0 0 0	0 44.00
45.00 04500 NURSING FACILITY 0 0 0 0	0 45.00
46. 00 04600 OTHER LONG TERM CARE 0 0 0 0	0 46.00
ANCI LLARY SERVI CE_COST_CENTERS 50. 00 05000 0PERATI NG_ROOM 37, 696 37, 696 5, 791, 158 0 20, 192	3, 452 50. 00
	4, 457 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0	0 52.00
	1,709 53.00
	3, 704 54. 00 4, 403 54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0	0 55.00
56. 00 05600 RADI 0I SOTOPE 0 0 0	0 56.00
57.00 05700 CT SCAN 0 0 0 0	0 57.00
58.00         05800         MRI         0 <th< td=""><td>0 58.00 0 59.00</td></th<>	0 58.00 0 59.00
	7, 135 60. 00
60. 01 06001 BLOOD LABORATORY 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         0         0         0         0         0           63. 00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0         0         0         0	0 62.00 0 63.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0	0 64.00
65. 00 06500 RESPI RATORY THERAPY 0 0 1, 981 0 33	5, 078 65. 00
	6, 683 66. 00
67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	0 67.00
68. 00         06800         SPEECH         PATHOLOGY         0	0 68.00 7,154 69.00
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 865	5, 962 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 20, 06	
73. 00         07300         DRUGS         CHARGED         TO         PATIENTS         O         O         O         88'           74. 00         07400         RENAL         DI ALYSIS         O         O         O         O         0         <	7, 517 73.00 0 74.00
75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0	0 75.00
77.00 07700 ALLOĜENEI C HSCT ACQUI SÍ TI ON 0 0 0	0 77.00
88.00         08800         RURAL         HEALTH         CLINIC         0         0         0         0           89.00         08900         FEDERALLY         QUALIFIED         HEALTH         CENTER         0         0         0         0         0	0 88.00 0 89.00
90. 00 09000 CLINIC 0 0 0 0	0 90.00
91.00 09100 EMERGENCY 0 0 0	0 91.00
92. 00  09200  OBSERVATI ON BEDS (NON-DI STINCT PART	92.00

alth Financial Systems NST ALLOCATION - STATISTICAL BASIS		THERAN MUSCULOS	Provider C	CN: 15-0168	Period:	Worksheet B-1	
					From 01/01/2022	Data /Tima Dra	
					To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
		CAPI TAL REL	ATED COSTS				
Cost Center Description		BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	0.00	SALARI ES)	<b>E A</b>		
OTHER REIMBURSABLE COST CENTER	c	1.00	2.00	4.00	5A	5.00	-
. 00 09400 HOME PROGRAM DI ALYSI S	5	0	0		0 0	0	94.
6. 00 09500 AMBULANCE SERVICES		0	-		0 0	C	
0 09600 DURABLE MEDICAL EQUIP-RE	NTED	0			0 0	C	
. 00 09700 DURABLE MEDICAL EQUIP-SO		0	0		0 0	0	
8.00 09850 OTHER REIMBURSABLE COSTS		0	0		0 0	C	98
0.00 09900 CMHC		0	0		0 0	C	99
2. 10 09910 CORF		0	0		0 0	0	99.
0.00 10000 I &R SERVICES-NOT APPRVD	PRGM	0	0		0 0	C	100
1.00 10100 HOME HEALTH AGENCY		0	0		0 0		101
02.00 10200 OPI OI D TREATMENT PROGRAM		0	0		0 0	0	102
SPECIAL PURPOSE COST CENTERS				[			1.05
05. 00 10500 KI DNEY ACQUI SI TI ON		0			0 0		105.
06.00 10600 HEART ACQUISITION 07.00 10700 LIVER ACQUISITION		0			0 0		106
00 10800 LUNG ACQUISITION		0			0 0		107
09. 00 10900 PANCREAS ACQUISTION		0					108.
0. 00 11000 I NTESTI NAL ACQUI SI TI ON		0			0 0		110
1. 00 11100 I SLET ACQUI SI TI ON		0	0		0 0		1111
3. 00 11300 INTEREST EXPENSE		_	-			-	113
4.00 11400 UTILIZATION REVIEW-SNF							114.
5.00 11500 AMBULATORY SURGICAL CENT	ER (D. P.)	0	0		0 0	0	115.
6. 00 11600 HOSPI CE		0	0		0 0	0	116.
8.00 SUBTOTALS (SUM OF LINES	1 through 117)	128, 407	128, 407	20, 905, 99	8 -16, 858, 618	69, 773, 581	118.
NONREI MBURSABLE COST CENTERS							
0.00 19000 GIFT, FLOWER, COFFEE SHO	P & CANTEEN	0			0 0		190
1. 00 19100 RESEARCH		0	-		0 0		191
22. 00 19200 PHYSI CLANS' PRI VATE OFFI	UES	36, 132	36, 132	1, 21		2, 575, 673	
23. 00 19300 NONPALD WORKERS		0	0		0 0		193
04.00 07950 SPORTS MEDICINE 04.01 07951 SENIOR CIRCLE		0	0		0 0	3, 245, 555	194
0.00 Cross Foot Adjustments					0	U	200.
1.00 Negative Cost Centers							200.
2.00 Cost to be allocated (pe	r Wkst. B.	4, 613, 697	7, 040, 749	5, 539, 41	0	16, 858, 618	
Part I)		., 0.0, 0,7		2,007,11		,,,	
)3.00 Unit cost multiplier (Wk	st. B, Part I)	28. 040142	42. 790761	0. 26495	2	0. 223013	203
04.00 Cost to be allocated (pe	r Wkst. B,			266, 60	)7	64, 788	204.
Part II)							
95.00 Unit cost multiplier (Wk	st. B, Part			0. 01275	2	0.000857	205
06.00 NAHE adjustment amount to	o be allocated						206
07.00 (per Wkst. B-2) NAHE unit cost multiplie							207.
		1	1		1		1/11/

		UTHERAN MUSCULO				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2022	Worksheet B-1	
				Т	0 12/31/2022	Date/Time Pre 5/31/2023 9:1	
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG		MAINTENANCE OF	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	PERSONNEL (NUMBER	
			LAUNDRY)			HOUSED)	
		7.00	8.00	9.00	10.00	12.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		[	1			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 00700 OPERATION OF PLANT	122 004					5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	132, 904	95, 492				7.00
9.00	00900 HOUSEKEEPI NG	0	0	132, 904			9.00
10.00	01000 DI ETARY	0	0	0	14, 073	_	10.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0		0	0	0	12.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	7,053		7,053	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	C	0	0	0	16.00
17.00 18.00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICES	0		0	0	0	17.00 18.00
	01900 NONPHYSICIAN ANESTHETISTS			0	0	0	
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0		0	0	0	22.00 23.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		<u> </u>	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	17, 152	78, 861	17, 152	14, 073	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C	0	0	0	
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	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0		0	0	0	
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	
	ANCI LLARY SERVI CE COST CENTERS	1	1	1	r		
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	37,696	16, 631			0	50.00 51.00
51.00	05200 DELIVERY ROOM & LABOR ROOM	10, 546		10, 546	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 285	C	3, 285	0	0	54.00
54.01 55.00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	
	05500 RADI OLOGY - THERAPEOTIC			0	0	0	55.00
	05700 CT SCAN	0	0	0	0	0	1
58.00	05800 MRI	0	C	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0	0	59.00
	06001 BLOOD LABORATORY			0	0	0	60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					Ū	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0	0	0	
		0	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0		0	0	0	64.00 65.00
	06600 PHYSI CAL THERAPY	21, 040		21, 040	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			0	0	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)			0	0	0	74.00
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	•
	OUTPATIENT SERVICE COST CENTERS	~	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			1
88.00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0		0	0	0	
90.00 91.00	09100 EMERGENCY	0		0	0	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
04.00	OTHER REIMBURSABLE COST CENTERS	-	-	-			0.0
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0				0	
,5.00	10,000 / MIDDENINGE DERVICED	1 0	ı 0	1 0	I U	0	1 , 5. 00

Health Fina	ncial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	R	In Lie	eu of Form CMS-	2552-1
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					rom 01/01/2022		
					o 12/31/2022		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/31/2023 9:1 MAINTENANCE OF	3 800
	cost center bescription	PLANT	LINEN SERVICE		(MEALS SERVED)		
		(SQUARE FEET)	(POUNDS OF	(SOUARE ILLI)	(WEALS SERVED)	(NUMBER	
		(SQUARE FEET)	LAUNDRY)			HOUSED)	
		7.00	8.00	9,00	10,00	12.00	
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	7.00	0.00	9.00			96.00
	D DURABLE MEDICAL EQUIP-SOLD	0	0		-	-	
	OTHER REIMBURSABLE COSTS	0	0			0	
		0	0			0	
	D CMHC D CORF	0	0				
		0	0		0	-	1
	DI&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
	DHOME HEALTH AGENCY	0	0	0			101.00
	O OPI OI D TREATMENT PROGRAM	0	0	(	0 0	0	102.00
	AL PURPOSE COST CENTERS						1.05 00
	KIDNEY ACQUISITION	0	0	(			105.00
	HEART ACQUISITION	0	0	C			106.00
	D LIVER ACQUISITION	0	0	C	-		107.00
	LUNG ACQUISITION	0	0	C	0 0		108.00
	PANCREAS ACQUISITION	0	0	0	0 0		109.00
	DINTESTINAL ACQUISITION	0	0	C	0 0		110.00
	DISLET ACQUISITION	0	0	0	0 0	0	111.00
113.00 11300	DINTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF						114.00
115.00 11500	DAMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0 0	0	115.00
116.00 11600	D HOSPI CE	0	0	0	0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	96, 772	95, 492	96, 772	2 14, 073	0	118.00
NONRE	EIMBURSABLE COST CENTERS						
190.00 1900	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	0	190. 00
191.00 1910	RESEARCH	0	0	0	0 0	0	191.00
192.00 1920	PHYSICIANS' PRIVATE OFFICES	36, 132	0	36, 132	0	0	192.00
193.00 1930	NONPAID WORKERS	0	0		0	0	193.00
194.0007950	SPORTS MEDICINE	0	0	(	0	0	194.00
	SENIOR CIRCLE	0	0	C	0	0	194.0
200.00	Cross Foot Adjustments	-		-	-	-	200.00
201.00	Negative Cost Centers	1					201.00
202.00	Cost to be allocated (per Wkst. B,	5, 493, 995	192, 492	652, 289	274, 603	0	202.00
202.00	Part I)	0, 1,0, ,,0	.,_, .,_	002,207	27 17 000		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	41. 338071	2.015792	4. 907971	19. 512755	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B,	1, 979, 125					204.00
2011 00	Part II)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100				201100
205.00	Unit cost multiplier (Wkst. B, Part	14.891388	0. 001414	0. 003634	0. 013643	0. 000000	205 00
200.00		1 7. 071300	0.001414	0.000004		0.00000	
206.00	NAHE adjustment amount to be allocated						206.00
200.00	(per Wkst. B-2)						200.00
207 00							207.00
207.00							
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						20

COST A	Financial Systems L LLOCATION - STATISTICAL BASIS	UTHERAN MUSCULUS	RELETAL CENTER	N: 15-0168 F	Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUI S. )	RECORDS & LI BRARY	(TIME SPENT)	
		(DI RECT NRSI NG HRS)	(COSTED REQUI S. )		(GROSS CHAR GES)		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION	7, 274, 966					13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	30, 820, 941 118, 720	887, 517	,		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	007, 517			16.00
17.00	01700 SOCIAL SERVICE	0	0	C		0	17.00
18.00	01850 OTHER GENERAL SERVICES	0	0	(	0	0	18.00
19.00 20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	(		0	19.00
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(		0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C	0 0	0	22.00
23.00	02300 PARAMED ED PRGM	0	0	(	00	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 242, 229	247, 665		14, 512, 514	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 242, 227	247,003	(		0	31.00
32.00	03200 CORONARY CARE UNI T	0	0	C		0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(		0	33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	(	-	0	34.00 40.00
40.00	04100 SUBPROVI DER – I RF	0	0	(		0	40.00
43.00	04300 NURSERY	0	0	C	0 0	0	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	-	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	(	-	0	45.00
40.00	ANCI LLARY SERVICE COST CENTERS		0		<u> </u>	0	1 40.00
50.00	05000 OPERATI NG ROOM	3, 219, 712	8, 399, 937	C		0	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 808, 399	0	(		0	51.00 52.00
52.00 53.00	05300 ANESTHESI OLOGY	0	34, 860	(	-	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	445	0	C		0	54.00
54.01	03630 ULTRA SOUND	0	0	C		0	
	05500 RADI OLOGY-THERAPEUTI C	0	0	(	0	0	00.00
	05600 RADI 0I SOTOPE 05700 CT SCAN	0	0	(		0	56.00 57.00
58.00	05800 MRI	0	0	C	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0 0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 129	63, 130	(	12, 539, 425	0	60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	c c		0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0 0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(		0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	ſ	0 0 0 689, 746	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	125, 419	(	44, 549, 115		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	(		0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 052	0	(	_,,	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	707, 497	(	-	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	20, 234, 855	(	358, 560, 892	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	887, 517 0	887, 517			73.00
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	(		0	74.00 75.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(	, v	0	77.00
	OUTPATIENT SERVICE COST CENTERS				-1	-	
	08800 RURAL HEALTH CLINIC	0	0	(	0	0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	( (	0 וע ה (נ	0	
90.00 91.00	09100 EMERGENCY	0	0	(	o o	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.00	OTHER REIMBURSABLE COST CENTERS						/2.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
				From 01/01/2022		
				To 12/31/2022		
					5/31/2023 9:1	<u>3 am</u>
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
	(DIRECT NRSING	(COSTED		(GROSS CHAR		
	HRS)	REQUIS.)		GES)		
	13.00	14.00	15.00	16.00	17.00	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	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 OI D TREATMENT PROGRAM	0	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 ACQUI SI TI ON	0	Ö		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUISITION	0	0		0 0		107.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110,00
	0	0		0 0		111.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 274, 966	30, 819, 600	887, 5	17 946, 202, 806	0	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·			-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 341		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.00 07950 SPORTS MEDICINE	0	0		0 0	0	194.00
194.01 07951 SENI OR CI RCLE	0	o		0 0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	1, 451, 254	4, 134, 270	609, 1	50 934, 652	0	202.00
Part I)	.,,	.,				
203.00 Unit cost multiplier (Wkst. B, Part I)	0, 199486	0. 134138	0.6863	0, 000988	0. 000000	203 00
204.00 Cost to be allocated (per Wkst. B,	11, 970	615, 907	6, 2			204.00
Part II)	, ,,,0	515, 707	0, 2	702		
205.00 Unit cost multiplier (Wkst. B, Part	0, 001645	0. 019983	0, 0069	0. 000001	0. 000000	205 00
	0.001043	0.017703	0.0007			200.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						207.00
	i I	I		ļ	I	I

COST ALLOCATION - STATISTICAL BASIS         Provider CCN: 15-0168         Period: From 01/01/2022 To 12/31/2023         Worksheet B-1 Date/Time Prepare 5/31/2023 9: 13 ar           Image: Cost Center Description         OTHER GENERAL SERVICE         OTHER GENERAL SERVICE         NURSING (TIME SPENT)         NURSING ANESTHETISTS (ASSIGNED TIME)         INTERNS & RESIDENTS         SERVICES-SALAR APPRV (ASSIGNED TIME)         SERVICES-SALAR V & FRINGES APPRV (ASSIGNED TIME)         PROM COSTS APPRV (ASSIGNED TIME)         APPRV (ASSIGNED TIME)         APPRV (ASSIGNED TIME) <td< th=""><th>2-10</th></td<>	2-10
Cost Center Description         OTHER GENERAL SERVICE         NONPHYSICIAN (TI ME SPENT)         NURSING ABESTHETISTS (ASSIGNED TI ME)         INTERNS & RESIDENTS         RESIDENTS           0         0         0         0         0         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         22.00         20.00         22.00         20.00         22.00	
Cost Center Description         OTHER GENERAL SERVICE         NURSING (TI ME SPENT)         NURSING ANESTHETISTS (ASSIGNED TI ME)         NURSING V & FRINCES-SALAR SERVICES-SALAR SERVICES-SALAR SERVICES-SALAR APPRV (ASSIGNED TI ME)           0THER REI MBURSABLE COST CENTERS         18.00         19.00         20.00         21.00         22.00           94.00         09400   HOME PROGRAM DI ALYSIS         0         0         0         0         0         0         95.00           95.00         09500 AMBULANCE SERVICES         0         0         0         0         0         0         95.00           96.00         09600 DURABLE MEDI CAL EQUIP-RENTED         0         0         0         0         0         95.00           97.00         09700 DURABLE MEDI CAL EQUIP-SOLD         0         0         0         0         0         0         97.00           98.00         09800 CMHC         CEF         0         0         0         0         0         0         97.00           99.10         09900 CMHC         SERVI CES-NOT APPRVD PRGM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< td=""><td></td></td<>	
OTHER CENERAL SERVICE         ONNPHYSICIAN ANESTHETISTS (ASSIGNED TIME)         NURSING PROGRAM (ASSIGNED TIME)         INTERNS & RESIDENTS           94.00         OP400 HOME PROGRAM DI ALYSIS         0         0         0         22.00           94.00         O9500 AMBULANCE SERVICES         0         0         0         0         0         94.00           94.00         O9500 AMBULANCE SERVICES         0         0         0         0         0         0         0         94.00         09500 AMBULANCE SERVICES         0         0         0         0         95.00         0         0         0         0         96.00         09500 AMBULANCE SERVICES         0         0         0         0         0         97.00         09700 DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         97.00         09900 CMHC         0         0         0         0         0         99.00         99900 CMHC         0	
SERVICE         NONPHYSICIAN         NURSING         SERVICE-SALAS         PROMOSIS           Cost Center Description         S         (TIME SPENT)         NONPHYSICIAN         NURSING         SERVICES-SALAS         PROMOSIS         APPRV         (ASSIGNED)         PROMOSIS         APPRV         (ASSIGNED)         TIME)         TIME)         TIME)         TIME)         (ASSIGNED)         TIME)         TIME)         TIME)         TIME)         TIME)         (ASSIGNED)         TIME)         TIME) <td><u> </u></td>	<u> </u>
Cost Center Description         S (TI ME SPENT)         NONPHYSICIAN ARESTHETISTS (ASSI GNED) TI ME)         NUNPHYSICIAN PROGRAM (ASSI GNED) TI ME)         SERVI CES-SALAR PROM COSTS APPRV (ASSI GNED) TI ME)         SERVI CES-OTHER PROM COSTS APPRV (ASSI GNED) TI ME)           94.00         09400         HOME PROGRAM DI ALYSI S         0         0         0         22.00         21.00         22.00           95.00         09500         AMBURANCE SERVI CES         0         0         0         0         0         94.00         97.00         0         0         0         94.00         99.00         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         96.00         99500         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         97.00         997.00         DVRABLE MEDI CAL EQUI P-SOLD         0         0         0         97.00         99.00         0         0         0         0         98.00         99.00         0         0         0         0         0         99.00         0         0         0         0         0         0         99.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	
Image: Contract of the second secon	
TIME         TIME         CASSIGNED TIME         CASSIGNED TIME         CASSIGNED TIME           94.00         09400         HOME PROGRAM DI ALYSIS         0         0         0         0         0         94           95.00         09500         AMBULANCE SERVICES         0         0         0         0         94           96.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         95           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         97           98.00         09550         OTHER REI MBURSABLE COSTS         0         0         0         0         97           99.10         09910         CORF         0         0         0         0         0         99           99.10         09910 CORF         0 <td></td>	
OTHER         REI MBURSABLE         COST         CENTRES           94.00         09400         HOME         PROGRAM         DI ALYSI S         0         0         0         0         94         95         0         0         0         0         0         94         0         09400         HOME         PROGRAM         DI ALYSI S         0         0         0         0         94         95         0         0         0         0         0         0         94         95         0         0         0         0         0         94         95         0         0         0         0         0         94         95         0         0         0         0         0         94         95         0         96         0         0         0         0         95         96         0         96         0         0         0         0         96         97         00         9850         0         9850         0         99         0         0         0         0         0         0         99         10         09910         CORF         0         0         0         0         0         0         0	
Image: 18.00         19.00         20.00         21.00         22.00           94.00         09400         HOME PROGRAM DI ALYSI S         0         0         0         0         94.00           95.00         09500         AMBULANCE SERVI CES         0         0         0         0         95.00           96.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         96.00           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         97.00           98.00         09800         OHHC         0         0         0         0         99.00           99.00         09900 CMHC         0         0         0         0         0         99.91           100.00         10000 L&R SERVI CES-NOT APPRVD PRGM         0	
OTHER         REI MBURSABLE         COST         CENTERS           94.00         09400         HOME         PROGRAM         DI ALYSI S         0         0         0         0         94           95.00         09500         AMBULANCE         SERVI CES         0         0         0         0         95           96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED         0         0         0         0         96           97.00         09700         DURABLE         MEDI CAL         EQUI P-SOLD         0         0         0         0         96           97.00         09700         DURABLE         COSTS         0         0         0         0         0         97           98.00         09850         OTHER         REI MBURSABLE         COSTS         0         0         0         0         99           99.00         09900         CMHC         0         <	
94.00       09400       HOME       PROGRAM       DI ALYSI S       0       0       0       0       0       94         95.00       09500       AMBULANCE SERVI CES       0       0       0       0       0       95         96.00       09600       DURABLE       MEDI CAL       EQUI P-RENTED       0       0       0       0       96         97.00       09700       DURABLE       MEDI CAL       EQUI P-SOLD       0       0       0       0       97         98.00       09850       OTHER       REI MBURSABLE       COSTS       0       0       0       97         99.00       09900       CMHC       0       0       0       0       99       99       0       09901       CORF       0       0       0       99         100.00       10000       I & R SERVI CES-NOT APPRVD       PRGM       0       0       0       0       0       0       0       100         101.00       10100       HOME HEALTH       AGENCY       0       0       0       0       0       0       101         102.00       DPI OI D       TREATMENT       PROGRAM       0       0       0 <td></td>	
95.00       09500       AMBULANCE SERVICES       0       0       0       0       95         96.00       09600       DURABLE MEDICAL EQUIP-RENTED       0       0       0       0       96         97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       0       0       97         98.00       09850       OTHER REIMBURSABLE COSTS       0       0       0       0       97         98.00       09900       CMHC       0       0       0       0       0       98         99.00       09900       CMHC       0       0       0       0       98         99.10       09910       CORF       0       0       0       0       99         100.01       1000       I & SERVI CES-NOT APPRVD PRGM       0       0       0       0       100         101.00       10100       HOME HEALTH AGENCY       0       0       0       0       0       100         102.00       IPIOID TREATMENT PROGRAM       0       0       0       0       0       101         102.00       IPIOID TREATMENT PROGRAM       0       0       0       0       0       101      <	00
96.00         09600         DURABLE MEDI CAL EQUI P-RENTED         0         0         0         96         0         0         0         97         0         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         0         97         00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         0         0         0         0         0         97         98         00         09850         OTHER REI MBURSABLE COSTS         0         0         0         0         0         0         98         99         00         09900         CMRC         0         0         0         0         0         0         0         0         0         99         100         0910         CORF         0	. 00
97.00       09700       DURABLE MEDI CAL EQUI P-SOLD       0       0       0       97         98.00       09850       OTHER REI MBURSABLE COSTS       0       0       0       0       98         99.00       09900       CMHC       0       0       0       0       98         99.00       09900       CMHC       0       0       0       0       99         99.00       09900       CMF       0       0       0       0       99         100.00       168       SERVI CES-NOT APPRVD PRGM       0	. 00
98.00       09850       0THER REIMBURSABLE COSTS       0       0       0       0       98         99.00       09900       CMHC       0       0       0       0       99         99.10       09910       CORF       0       0       0       0       99         100.00       I &R SERVI CES-NOT APPRVD PRGM       0       0       0       0       0       0       100         101.00       1000       HEALTH AGENCY       0       0       0       0       0       0       0       101         102.00       1020       OPI 0 I D TREATMENT PROGRAM       0 <td>. 00</td>	. 00
99.00         09900         CMHC         0         0         0         99           99.10         09910         CORF         0         0         0         0         99           100.00         1000         I &R SERVICES-NOT APPRVD PRGM         0	. 00
100. 00         10000         I &R SERVICES-NOT APPRVD PRGM         0         0         0         0         100           101. 00         1010         HOME HEALTH AGENCY         0         0         0         0         0         101           102. 00         10200         OPIOLD TREATMENT PROGRAM         0         0         0         0         0         102           SPECIAL PURPOSE COST CENTERS           105. 00         10500         KI DNEY ACQUI SI TI ON         0         0         0         0         105           106. 00         10600         HEART ACQUI SI TI ON         0         0         0         0         106           107. 00         10600         LIVER ACQUI SI TI ON         0         0         0         0         0         1070           107. 00         10800         LIVER ACQUI SI TI ON         0         0         0         0         0         1070           108. 00         10800         LIVER ACQUI SI TI ON         0         0         0         0         0         108           109. 00         10900         PANCREAS ACQUI SI TI ON         0         0         0         0         0         0         0 <td< td=""><td>. 00</td></td<>	. 00
101.00         1010         HOME         HEALTH         AGENCY         0         0         0         0         101           102.00         OPIOID         TREATMENT         PROGRAM         0         0         0         0         0         0         102           SPECIAL PURPOSE COST CENTERS           105.00         10500         KI DNEY         ACQUI SI TI ON         0         0         0         0         105           106.00         16600         HEART         ACQUI SI TI ON         0         0         0         0         0         106           107.00         LI VER         ACQUI SI TI ON         0	. 10
102.00         010200         0PIOLD TREATMENT PROGRAM         0         0         0         0         102           SPECIAL PURPOSE COST CENTERS	. 00
SPECIAL PURPOSE COST CENTERS           105. 00 10500         KI DNEY ACQUI SI TI ON         0         0         0         0         105           106. 00 10600         HEART ACQUI SI TI ON         0         0         0         0         106           107. 00 10700         LI VER ACQUI SI TI ON         0         0         0         0         107           107. 00 10700         LI VER ACQUI SI TI ON         0         0         0         0         107           108. 00 10800         LUNG ACQUI SI TI ON         0         0         0         0         108           109. 00         10900         PANCREAS ACQUI SI TI ON         0         0         0         0         109	. 00
105.00       10500       KI DNEY ACQUI SI TI ON       0       0       0       0       105         106.00       10600       HEART ACQUI SI TI ON       0       0       0       0       0       106         107.00       10700       LI VER ACQUI SI TI ON       0       0       0       0       0       0       107         108.00       10800       LUNG ACQUI SI TI ON       0       0       0       0       108         109.00       10900       PANCREAS ACQUI SI TI ON       0       0       0       0       0	. 00
106.00         10600         HEART ACQUI SI TI ON         0         0         0         106         0         106         107         107         00         107         00         107         00         107         00         107         00         0         0         0         107         107         108         00         107         00         00         0         0         107         107         108         00         108         00         108         00         108         00         00         00         00         108         109         00         109         00         00         00         00         109         109         109         00         109         00	
107.00         10700         LI VER ACQUI SI TI ON         0         0         0         0         0         107           108.00         10800         LUNG ACQUI SI TI ON         0	
108.00         LUNG ACQUISITION         0         0         0         0         0         0         108           109.00         PANCREAS ACQUISITION         0	
109.00 10900 PANCREAS ACQUISITION 0 0 0 0 0	
TIU. UUTIUUUUTNIESTINAL ACQUISTITUN UUUUTUUUUUUUUUUUUUUUUUUUUUUUUUUUUU	
111. 00 11100 I SLET ACQUI SI TI ON 0 0 0 0 111	
	. 00
	. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 115	
	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 0	
NONREIMBURSABLE COST CENTERS	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190	. 00
191.00 19100 RESEARCH 0 0 0 0 0 191	. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192	. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193	
194. 00 07950 SPORTS MEDI CI NE 0 0 0 0 0 194	
194. 01 07951 SENI OR CI RCLE 0 0 0 0 0194	
	. 00
	. 00
202.00         Cost to be allocated (per Wkst. B,         0	. 00
Part I)         203.00         Unit cost multiplier (Wkst. B, Part I)         0.000000	00
203.00 Cost to be allocated (per Wkst. B, Control of the cost of t	
Part II)	. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 0.000000 0.000000	00
	. 00
(per Wkst. B-2)	
	. 00
Parts III and IV)	

ST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0168	Peri od: From 01/01/2022	Worksheet B-1	
			To 12/31/2022	Date/Time Prep. 5/31/2023 9:13	
Cost Center Description	PARAMED ED PRGM (ASSI GNED TI ME) 23.00				
GENERAL SERVICE COST CENTERS					
00         00100         CAP         REL         COSTS-BLDG         & FIXT           00         00200         CAP         REL         COSTS-MVBLE         EQUIP           00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           00         00500         ADMI NI STRATI VE         & GENERAL           00         00700         OPERATION         OF         PLANT           00         00800         LAUNDRY         & LINEN         SERVICE           00         00900         HOUSEKEEPING         00         00900           00         01200         MAINTENANCE         OF         PERSONNEL           00         01200         MAINTENANCE         OF         PERSONNEL           00         01200         NURSI NG         ADMI NI STRATION         00         01400         CENTRAL         SERVICES         SUPPLY           00         01500         PHARMACY         00         01500         PHARMACY         00         01500         MAENACY           00         01500         OTHER         GENERAL         SERVICES         00         01900         NONPHYSICI AN ANESTHETISTS           00         01700         SOCI AL         SERVICES<	APPRV				1. 2. 4. 5. 7. 8. 9. 10. 12. 13. 14. 15. 16. 17. 18. 20. 21. 22. 22.
5. 00 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENT	ERS 0				23.
0.00         03000         ADULTS         & PEDIATRICS           .00         03100         INTENSIVE         CARE         UNIT           .00         03200         CORONARY CARE         UNIT           .00         03200         BURN INTENSIVE         CARE         UNIT           .00         03400         BURN INTENSIVE         CARE         UNIT           .00         03400         SURGICAL         INTENSIVE         CARE         UNIT           .00         04000         SUBPROVIDER         - IPF         .00         04100         SUBPROVIDER         - IFF           .00         04100         SUBPROVIDER         - IRF         .00         04300         NURSERY           .00         04400         SKILLED         NURSING         FACILITY         .00         04500         NURSING         FACILITY           .00         04500         NURSING         FACILITY         .00         04600         OTHER         LONG         TERM         CARE					<ol> <li>30.</li> <li>31.</li> <li>32.</li> <li>33.</li> <li>34.</li> <li>40.</li> <li>41.</li> <li>43.</li> <li>44.</li> <li>45.</li> <li>46.</li> </ol>
ANCI LLARY SERVI CE COST CENTERS	0				50.
.00         05100         RECOVERY ROOM           2.00         05200         DELI VERY ROOM & LABOR ROOM           2.00         05300         ANESTHESI OLOGY           2.00         05400         RADI OLOGY-DI AGNOSTI C           2.01         03630         ULTRA SOUND           2.00         05500         RADI OLOGY-THERAPEUTI C           2.00         05600         RADI AC CATHETERI ZATI ON           0.00         05900         CARDI AC CATHETERI ZATI ON           0.00         06400         LABORATORY           0.01         06000         LABORATORY           0.01         06000         BLOOD LABORATORY           0.01         06000         LABORATORY           0.01         06000         BLOOD STORI NG, PROCESSI NG & T           0.00         06400         INTRAVENOUS THERAPY           0.00         06400         INTRAVENOUS THERAPY	M ONLY D CELL RANS. ATI ENT S O O O O O O O O O O O O O O O O O O				$\begin{array}{c} 51.\\ 52.\\ 53.\\ 54.\\ 55.\\ 55.\\ 57.\\ 57.\\ 57.\\ 57.\\ 60.\\ 61.\\ 62.\\ 63.\\ 64.\\ 66.\\ 66.\\ 67.\\ 71.\\ 72.\\ 73.\\ 74.\\ 75.\\ 77.\\ \end{array}$
00 08800 RURAL HEALTH CLINIC     00 08900 FEDERALLY QUALIFIED HEALTH CE     00 09000 CLINIC     00 09100 EMERGENCY     00 09200 OBSERVATION BEDS (NON-DISTINC	0				88. 89. 90. 91. 92.
OTHER REIMBURSABLE COST CENTERS					
. 00 09400 HOME PROGRAM DIALYSIS . 00 09500 AMBULANCE SERVICES	0				94 95

ealth Financial Systems LU :OST ALLOCATION - STATISTICAL BASIS	THERAN MUSCULOSK	Provi der CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet B-1	
UST ALLOCATION - STATISTICAL DASIS		Provider CCN. 15-0108	From 01/01/2022	WULKSHEEL D-I	
			To 12/31/2022	Date/Time Prep 5/31/2023 9:13	
Cost Center Description	PARAMED ED			0/01/2020 /. 10	
	PRGM				
	(ASSI GNED				
	TIME)				
	23.00				
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0				96.0
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0				97.0
8. 00 09850 OTHER REI MBURSABLE COSTS	0				98.0
9. 00 09900 CMHC	0				99.0
9. 10 09910 CORF	0				99.1
00.00 10000 I&R SERVICES-NOT APPRVD PRGM	0				100. 0
01.00 10100 HOME HEALTH AGENCY	0				101.0
02.00 10200 OPI OI D TREATMENT PROGRAM	0				102. (
SPECIAL PURPOSE COST CENTERS	· .				
05. 00 10500 KI DNEY ACQUI SI TI ON	0				105. (
06.00 10600 HEART ACQUI SI TI ON	0				106. (
07.00 10700 LIVER ACQUISITION	0				107. (
08.00 10800 LUNG ACQUISITION	0				108. (
09. 00 10900 PANCREAS ACQUISITION	0				109.
10. 00 11000 INTESTINAL ACQUISITION	0				110.
11.00 11100 I SLET ACQUI SI TI ON	0				111.
13.00 11300 INTEREST EXPENSE					113.
14.00 11400 UTI LI ZATI ON REVI EW-SNF					114.
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0				115. (
16.00 11600 HOSPI CE	0				116. (
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	0				118. (
NONREI MBURSABLE COST CENTERS					
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190. (
91. 00 19100 RESEARCH	0				191. (
92. 00 19200 PHYSICIANS' PRIVATE OFFICES	0				192. (
93. 00 19300 NONPALD WORKERS	0				193. (
94.00 07950 SPORTS MEDICINE	0				194. (
94. 01 07951 SENI OR CI RCLE	0				194.
00.00 Cross Foot Adjustments					200.
01.00 Negative Cost Centers					201.
02.00 Cost to be allocated (per Wkst. B,	0				202.
Part I)					1
03.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000				203. (
04.00 Cost to be allocated (per Wkst. B, Part II)	0				204.
05.00 Unit cost multiplier (Wkst. B, Part	0. 000000				205.
06.00 NAHE adjustment amount to be allocated	0				206.
(per Wkst. B-2)					
07.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000				207.

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0168	Peri od:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	pare
					5/31/2023 9:1	
			e XVIII	<u>Hospital</u> Costs	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
·	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	-
INPATIENT ROUTINE SERVICE COST CENTERS						
0.00 03000 ADULTS & PEDIATRICS	8, 378, 289		8, 378, 28		8, 378, 289	
1.00 03100 INTENSIVE CARE UNIT	0			0 0	0	
2. 00 03200 CORONARY CARE UNIT 3. 00 03300 BURN INTENSIVE CARE UNIT				0 0	0	32
4. 00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
D. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40
I. 00 04100 SUBPROVIDER - IRF	0	)		0 0	0	
3. 00 04300 NURSERY	0			0 0	0	
1. 00 04400 SKILLED NURSING FACILITY 5. 00 04500 NURSING FACILITY				0 0	0	
5. 00 04600 OTHER LONG TERM CARE	0			0 0	0	
ANCILLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	28, 536, 253		28, 536, 25		28, 536, 253	
	5, 597, 290		5, 597, 29		5, 597, 290	
2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESIOLOGY	82, 718		82, 7	-	0 82, 718	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 390, 576		1, 390, 57	-	1, 390, 576	
4. 01 03630 ULTRA SOUND	5, 420		5, 42		5, 420	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
6. 00 05600 RADI OI SOTOPE	0			0 0	0	
7. 00   05700  CT SCAN 8. 00   05800  MRI	0				0	
9. 00 05900 CARDI AC CATHETERI ZATI ON				0 0	0	
0. 00 06000 LABORATORY	592, 594		592, 59		592, 594	
D. 01 06001 BLOOD LABORATORY	0			0 0	0	60
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0 0	0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	_ 0			0 0	0	
3. 00     06300     BLOOD     STORING,     PROCESSING & TRANS.       4. 00     06400     INTRAVENOUS     THERAPY					0	1
5. 00 06500 RESPI RATORY THERAPY	43, 582	C	43, 58	32 0	43, 582	
6. 00 06600 PHYSI CAL THERAPY	8, 270, 035	C	8, 270, 03	35 0	8, 270, 035	66
7.00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 0	0	
8. 00  06800  SPEECH PATHOLOGY 9. 00  06900  ELECTROCARDI OLOGY	84, 749		84, 74	0 0	0 84, 749	
0.00 07000 ELECTROEARDTOEOGT	04,749		04,74	0 0	04,749	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	۰ 1, 214, 199		1, 214, 19	09 0	1, 214, 199	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	27, 609, 858	5	27, 609, 85		27, 609, 858	72
3. 00 07300 DRUGS CHARGED TO PATIENTS	1, 857, 201		1, 857, 20		1, 857, 201	
4.00 07400 RENAL DIALYSIS 5.00 07500 ASC (NON-DISTINCT PART)	83		5	33 0 0 0	83 0	
7. 00 07700 ALLOGENEIC HSCT ACQUISITION				0 0	0	
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
0. 00 09000 CLINIC 1. 00 09100 EMERGENCY				0 0	0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 600, 844		2, 600, 84	14	2, 600, 844	
OTHER REIMBURSABLE COST CENTERS	_,,		_,, .		_, ,	
4.00 09400 HOME PROGRAM DI ALYSI S	0	)		0 0	0	
5. 00 09500 AMBULANCE SERVICES	0			0 0	0	1
6.00 09600 DURABLE MEDICAL EQUIP-RENTED 7.00 09700 DURABLE MEDICAL EQUIP-SOLD					0	
B. 00 09850 OTHER REIMBURSABLE COSTS	0			0 0	0	
9. 00 09900 CMHC	0			0	0	
9. 10 09910 CORF	0			0	0	
00.00 10000 I&R SERVICES-NOT APPRVD PRGM	0			0		100
01. 00 10100 HOME HEALTH AGENCY 02. 00 10200 OPI OI D TREATMENT PROGRAM	0			0		101 102
SPECIAL PURPOSE COST CENTERS		1	1		0	
D5. 00 10500 KI DNEY ACQUI SI TI ON	0	)		0	0	105
D6. 00 10600 HEART ACQUI SI TI ON	0			0	0	106
D7. 00 10700 LIVER ACQUISITION	0			0		107
08. 00 10800 LUNG ACQUISITION	0			0		108
09.00 10900 PANCREAS ACQUISITION 10.00 11000 INTESTINAL ACQUISITION	0			0		109 110
11. 00 11100 I SLET ACQUISITION				0		111
13. 00 11300 I NTEREST EXPENSE					0	113
14. 00 11400 UTI LI ZATI ON REVI EW-SNF						114
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.)			1	0	0	115

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENT	ĒR	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-0168	Period: From 01/01/2022 To 12/31/2022			
		Titl	e XVIII	Hospi tal	PPS		
				Costs			
Cost Center Description	Total Cost	Therapy Limi	t Total Costs	s RCE	Total Costs		
	(from Wkst. B,	Adj.		Di sal I owance			
	Part I, col.	-					
	26)						
	1.00	2.00	3.00	4.00	5.00		
116.00 11600 HOSPI CE	0			0	0	116.00	
200.00 Subtotal (see instructions)	86, 263, 691		0 86, 263, 6	91 0	86, 263, 691	200.00	
201.00 Less Observation Beds	2, 600, 844		2, 600, 8	44	2, 600, 844	201.00	
202.00 Total (see instructions)	83, 662, 847		0 83, 662, 8	47 0	83, 662, 847	202.00	

	Financial Systems LL ATION OF RATIO OF COSTS TO CHARGES	JTHERAN MUSCULOS	Provider C	CN: 15-0168 F F 1	Period: From 01/01/2022 Fo 12/31/2022	u of Form CMS-: Worksheet C Part I Date/Time Pre 5/31/2023 9:1	epared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	0 ( 40 400		0 (40 40)			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	8, 640, 139		8, 640, 139			30.00
	03200 CORONARY CARE UNIT	0					32.00
	03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		(			34.00
40.00	04000 SUBPROVI DER - I PF	0		(	0		40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0					41.00
44.00	04400 SKILLED NURSING FACILITY	0					44.00
	04500 NURSING FACILITY	0		0	b		45.00
46.00	04600 OTHER LONG TERM CARE	0			)		46.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	(0.141.050	236, 976, 902		0. 096044	0,000000	50.00
50.00 51.00	05100 RECOVERY ROOM	60, 141, 059 7, 348, 807	52, 609, 790			0. 000000 0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	C	) ()		0. 000000	
53.00	05300 ANESTHESI OLOGY	7, 582, 185	19, 777, 491		0. 003023	0.000000	53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 996, 143	20, 541, 310			0.000000	
54.01 55.00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	35, 516	0	35, 516	0. 152607 0. 000000	0. 000000 0. 000000	
56.00	05600 RADI OLOGI - ITILKAP LOTI C	0	0		0. 000000	0.000000	
57.00	05700 CT SCAN	0	C	) (	0. 000000	0. 000000	
58.00	05800 MRI	0	C	) (	0. 000000	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0.000000	0.000000	
	06000 LABORATORY 06001 BLOOD LABORATORY	5, 703, 006	6, 836, 419	12, 539, 425	0. 047258 0. 000000	0. 000000 0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0. 000000	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0.000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	) (	0. 000000	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	C		0.000000	0.000000	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	490, 992 3, 576, 464	198, 754 40, 972, 651			0. 000000 0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	40, 772, 031	) 44, 347, 113		0. 000000	
	06800 SPEECH PATHOLOGY	0	C	) (	0. 000000	0.000000	
	06900 ELECTROCARDI OLOGY	646, 293	1, 590, 877	2, 237, 170		0.000000	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 23, 544, 051	0 37, 401, 736	60, 945, 787	0.000000 0.019923	0. 000000 0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	161, 856, 585	196, 704, 307			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 342, 008	30, 733, 347			0. 000000	
	07400 RENAL DIALYSIS	81, 635	1, 964			0.000000	
	07500 ASC (NON-DI STI NCT PART)	0	C		0.000000	0.000000	
//.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	C	) (	0. 000000	0.00000	77.00
88.00	08800 RURAL HEALTH CLINIC	0	C	) (	)		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	) (	D		89.00
		0	C		0.000000	0.000000	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	576, 242	5, 296, 133	5, 872, 375	0.000000 0.442895	0. 000000 0. 000000	
	OTHER REIMBURSABLE COST CENTERS		-,,				
	09400 HOME PROGRAM DI ALYSI S	0	C	) (	0. 000000	0.00000	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0.000000 0.000000	0. 000000 0. 000000	
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0. 000000	0.000000	
	09850 OTHER REI MBURSABLE COSTS	0	C		0.000000	0. 000000	
	09900 CMHC	0	C	) (			99.00
	09910 CORF	0	C		)		99.10
	10000 I & R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	C		)		100.00
	10200 OPI OLD TREATMENT PROGRAM	0	C				102.00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	C	) ()	)		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	C				106.00
	10800 LUNG ACQUISITION	0	C C				107.00
	10900 PANCREAS ACQUI SI TI ON	0	C				109.00
	11000 INTESTINAL ACQUISITION	0	C	) (			110.00
	11100 I SLET ACQUI SI TI ON	0	C				111.00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C				115.00
115.00	TISOU ANDULATURI SURGICAL CLINIER (D. F. )	UI UI	C C				1113.00

Health Fir	nancial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	Provider CCN: 15-0168		Worksheet C		
					From 01/01/2022			
					To 12/31/2022	Date/Time Pre 5/31/2023 9:2	epared: 13 am	
			Title	XVIII	Hospi tal	PPS		
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA		
				+ col. 7)	Ratio	Inpati ent		
						Rati o		
		6.00	7.00	8.00	9.00	10.00		
200.00	Subtotal (see instructions)	296, 561, 125	649, 641, 681	946, 202, 80	6		200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	296, 561, 125	649, 641, 681	946, 202, 80	6		202.00	

	*	UTHERAN MUSCULUSK			U OT FORM CMS-2552-1
COMPU	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0168	Period: From 01/01/2022	Worksheet C Part I
				To 12/31/2022	Date/Time Prepared: 5/31/2023 9:13 am
	Cret Creter Deceminting		Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio			
		11.00			
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T				30.0
32.00	03200 CORONARY CARE UNI T				32.0
33.00	03300 BURN INTENSIVE CARE UNIT				33. 0
34.00	03400 SURGI CAL INTENSI VE CARE UNI T				34. 0
40.00	04000 SUBPROVIDER - IPF				40.0
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY				41.0
44.00	04400 SKI LLED NURSI NG FACI LI TY				44. 0
45.00	04500 NURSING FACILITY				45.0
46.00	04600 OTHER LONG TERM CARE				46.0
50.00	ANCI LLARY SERVI CE COST CENTERS	0. 096044			50.0
51.00	05100 RECOVERY ROOM	0. 093353			51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53.00	05300 ANESTHESI OLOGY	0. 003023			53. 0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.059079			54.0
54.01 55.00	03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C	0. 152607 0. 000000			54.0 55.0
56.00	05600 RADI OLOGI - TILKAFEOTI C	0. 000000			56.0
57.00	05700 CT SCAN	0. 000000			57.0
58.00	05800 MRI	0. 000000			58.0
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 000000 0. 047258			59.00 60.00
60.00	06001 BLOOD LABORATORY	0. 000000			60.0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000 0. 063186			64. 0 65. 0
66.00	06600 PHYSI CAL THERAPY	0. 185639			66. 0
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68.00	06800 SPEECH PATHOLOGY	0. 000000			68. 0
69.00		0. 037882			69.0
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 019923			70.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 077002			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 042137			73.0
74.00	07400 RENAL DI ALYSI S	0. 000993			74.0
75.00 77.00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			75.0
//.00	OUTPATIENT SERVICE COST CENTERS	0.000000			
88.00	08800 RURAL HEALTH CLINIC				88.0
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.0
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0. 000000			90.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 442895			92.0
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000			94.0
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000 0. 000000			95.00 96.00
96.00	09700 DURABLE MEDICAL EQUIP-RENTED	0.000000			97.0
98.00	09850 OTHER REI MBURSABLE COSTS	0. 000000			98.0
99.00	09900 CMHC				99. 0
	09910 CORF				99.1
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY				100. 0 101. 0
	10100 OPI OI D TREATMENT PROGRAM				102. 0
	SPECIAL PURPOSE COST CENTERS				
	10500 KIDNEY ACQUISITION				105. 0
	10600 HEART ACQUISITION				106.0
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION				107.0 108.0
	10900 PANCREAS ACQUISITION				109. 0
	11000 I NTESTI NAL ACQUI SI TI ON				110. 0
	11100 I SLET ACQUI SI TI ON				111. 0
	11300 I NTEREST EXPENSE				113.0
	) 11400 UTILIZATION REVIEW-SNF ) 11500 AMBULATORY SURGICAL CENTER (D. P. )				114. 0 115. 0
110.00	11600 HOSPICE				116. 0
116.00					
116.00 200.00 201.00	Subtotal (see instructions)				200. 0 201. 0

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0168	Period: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
202.00 Total (see instructions)					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	<u> </u>	SKELETAL CENTER Provider C	CN: 15-0168 F	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 9:1	pared.
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS           31. 00         03100 I NTENSI VE CARE UNI T	8, 378, 289 0		8, 378, 289		8, 378, 289 0	
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0				0	33.00
34. 00         O3400         SURGI CAL         I NTENSI VE         CARE         UNI T           40. 00         04000         SUBPROVI DER         –         I PF           41. 00         04100         SUBPROVI DER         –         I RF					0 0 0	40.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	43.00 44.00
45. 00 04500 NURSI NG FACI LI TY 46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0 0	0	
50. 00 05000 OPERATI NG ROOM	28, 536, 253		28, 536, 253		28, 536, 253	
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	5, 597, 290 0 82, 718		5, 597, 290 0 82, 718	0 0	5, 597, 290 0 82, 718	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	1, 390, 576		1, 390, 576	0	1, 390, 576 5, 420	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0			0 0 0 0	0	55.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0		0	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	592, 594		592, 594		0 592, 594 0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				0	61.00
63. 00         06300         BLOOD         STORI NG,         PROCESSI NG & TRANS.           64. 00         06400         I NTRAVENOUS         THERAPY	0		0	0 0 0 0	0 0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	43, 582 8, 270, 035		43, 582 8, 270, 035		43, 582 8, 270, 035 0	66.00
68. 00 06800 SPECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 84, 749	0	84, 749		0 84, 749	68.00
70.00         07000         ELECTROENCEPHALOGRAPHY           71.00         07100         MEDI CAL_SUPPLI ES_CHARGED_TO_PATI ENT	0 1, 214, 199		( 1, 214, 199		0 1, 214, 199	71.00
72.00         07200         I MPL.         DEV.         CHARGED TO PATI ENTS           73.00         07300         DRUGS         CHARGED TO PATI ENTS           74.00         07400         RENAL         DI ALYSI S	27, 609, 858 1, 857, 201 83		27, 609, 858 1, 857, 201 83	0	27, 609, 858 1, 857, 201	
75. 00 07500 ASC (NON-DISTINCT PART) 77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0				0	75.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC					0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09900 CLINIC	0				0	89.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 600, 844		2, 600, 844	0	0 2, 600, 844	91.00
0THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S				) 0	0	
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 109850 OTHER REI MBURSABLE COSTS	0				0	97.00
99. 00 09900 CMHC 99. 10 09910 CORF	0				0	99.00
100.00 10000 I & R SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0				0	100. 00 101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0		(			102.00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0				0	105.00 106.00 107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION					0	107.00 108.00 109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON 111.00 11100 I SLET ACQUI SI TI ON					0	110,00 111,00
113.00 11300 INTEREST EXPENSE		1				113.00

Health Financial Systems LL	JTHERAN MUSCULOS	SKELETAL CENTE	R	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider (	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022		
			le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.	-				
	26)					
	1.00	2.00	3.00	4.00	5.00	
116.00 11600 HOSPI CE	0			0	0	116.00
200.00 Subtotal (see instructions)	86, 263, 691	(	86, 263, 69	91 0	86, 263, 691	200.00
201.00 Less Observation Beds	2,600,844		2, 600, 84	14	2, 600, 844	201.00
202.00 Total (see instructions)	83, 662, 847	(	83, 662, 84	47 0	83, 662, 847	202.00

COMPUT	Financial Systems LI ATION OF RATIO OF COSTS TO CHARGES			CN: 15-0168 F F 1	Period: From 01/01/2022 Fo 12/31/2022	u of Form CMS- Worksheet C Part I Date/Time Pre 5/31/2023 9:1	epared:
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	8, 640, 139		8, 640, 139			30.00
	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0					31.00
	03300 BURN INTENSIVE CARE UNIT	0		(			33.00
	03400 SURGICAL INTENSIVE CARE UNIT	0		0	)		34.00
40.00	04000 SUBPROVI DER – I PF	0		(			40.00
41.00	04100 SUBPROVIDER - IRF	0		(	0		41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0					43.00
	04500 NURSING FACILITY	0					45.00
	04600 OTHER LONG TERM CARE	0					46.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	60, 141, 059	236, 976, 902			0.00000	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	7, 348, 807	52, 609, 790	59, 958, 597		0. 000000 0. 000000	
52.00 53.00	05300 ANESTHESI OLOGY	7, 582, 185	19, 777, 491			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	2, 996, 143	20, 541, 310			0.000000	
54.01	03630 ULTRA SOUND	35, 516	C	35, 516	0. 152607	0.000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	) (	0. 000000	0.00000	
56.00	05600 RADI OI SOTOPE	0	C		0.00000	0.00000	
57.00 58.00	05700 CT SCAN 05800 MRI	0	C C		0.000000 0.000000	0. 000000 0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	0	C		0.000000	0. 000000	
60.00	06000 LABORATORY	5, 703, 006	6, 836, 419	12, 539, 425		0. 000000	
	06001 BLOOD LABORATORY	0	C	) (	0. 000000	0.00000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0.000000	0.00000	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0			0.000000 0.000000	0. 000000 0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	490, 992	198, 754	689, 746		0.000000	
66.00	06600 PHYSI CAL THERAPY	3, 576, 464	40, 972, 651	44, 549, 115		0.00000	
	06700 OCCUPATIONAL THERAPY	0	C		0.000000	0.00000	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	646, 293	1, 590, 877	2, 237, 170	0.000000 0.037882	0. 000000 0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	040, 273	1, 370, 077	2,257,170	0.000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 544, 051	37, 401, 736	60, 945, 787	0. 019923	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	161, 856, 585	196, 704, 307			0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 342, 008	30, 733, 347			0.00000	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	81, 635	1, 964			0. 000000 0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	C			0.000000	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	C		0. 000000	0.00000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0.000000 0.000000	0. 000000 0. 000000	
	09100 EMERGENCY	0	0		0. 000000	0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	576, 242	5, 296, 133	5, 872, 375		0. 000000	
	OTHER REIMBURSABLE COST CENTERS			1			
	09400 HOME PROGRAM DI ALYSI S	0	C		0.00000	0.00000	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0			0.000000 0.000000	0. 000000 0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0.000000	0. 000000	
	09850 OTHER REIMBURSABLE COSTS	0	C	) (	0.000000	0.000000	
	09900 CMHC	0	C	) (			99.00
	09910 CORF	0	C	) ()	)		99.10
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	C		)		100.00
	10200 OPI OLD TREATMENT PROGRAM	0	C				102.00
	SPECIAL PURPOSE COST CENTERS		-	-			
	10500 KIDNEY ACQUISITION	0	С	) (	0.000000	0. 000000	•
	10600 HEART ACQUI SI TI ON	0	C		0.00000	0.00000	
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0	C		0.000000 0.000000	0. 000000 0. 000000	
	10900 PANCREAS ACQUISITION	0	C C		0. 000000	0.000000	
	11000 INTESTINAL ACQUISITION	0	C		0. 000000	0. 000000	
111.00	11100 I SLET ACQUI SI TI ON	0	C		0. 000000	0. 000000	111.00
113.00	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
114.00	11500 AMBULATORY SURGICAL CENTER (D. P. )	0	~				115.00

Heal th Fi	nancial Systems	LUTHERAN MUSCULOS	SKELETAL CENTER	2	In Lieu of Form CMS-2552-10			
COMPUTATI	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-0168		Worksheet C Part I Date/Time Prepared: 5/31/2023 9:13 am		
			Titl	e XIX	Hospi tal	Cost		
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o		
		6.00	7.00	8.00	9.00	10.00		
200.00 201.00 202.00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	296, 561, 125 296, 561, 125			-		200. 00 201. 00 202. 00	

				From 01/01/2022 To 12/31/2022		
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio				
	1	11.00				
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					1 20 00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T					30.00
32.00	03200 CORONARY CARE UNIT					32.00
33.00	03300 BURN INTENSIVE CARE UNIT					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT					34.00
40.00	04000 SUBPROVI DER – I PF					40.00
41.00	04100 SUBPROVIDER - IRF					41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY					43.00
45.00	04500 NURSI NG FACI LI TY					45.00
46.00	04600 OTHER LONG TERM CARE					46.00
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0.00000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0. 000000 0. 000000				53.00 54.00
54.00	03630 ULTRA SOUND	0. 000000				54.00
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 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0.000000				60.00 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	0.00000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0. 000000 0. 000000				67.00 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 75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0. 000000 0. 000000				74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000				77.00
	OUTPATIENT SERVICE COST CENTERS	01000000				1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90.00	09000 CLINIC	0.00000				90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000 0. 000000				91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	0.000000				92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000				94.00
95.00	09500 AMBULANCE SERVICES	0. 000000				95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
98.00 99.00	09850 OTHER REI MBURSABLE COSTS	0. 000000				98.00
	09900 CMHC 09910 CORF					99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM					100.00
	10100 HOME HEALTH AGENCY					101.00
102.00	10200 OPI OI D TREATMENT PROGRAM					102.00
	SPECIAL PURPOSE COST CENTERS					4
	10500 KI DNEY ACQUI SI TI ON	0. 000000				105.00
	10600 HEART ACQUI SI TI ON 10700 LI VER ACQUI SI TI ON	0. 000000 0. 000000				106.00 107.00
	10700 LIVER ACQUISITION	0.000000				107.00
	10900 PANCREAS ACQUISITION	0. 000000				109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0. 000000				110.00
	11100 I SLET ACQUI SI TI ON	0. 000000				111.00
	11300 INTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE					115.00 116.00
200. OC						200.00
						200.00

Health Financial Systems	UTHERAN MUSCULOSK	ELETAL CENTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0168	From 01/01/2022	Worksheet C Part I Date/Time Pre 5/31/2023 9:1		
		Title XIX	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
202.00 Total (see instructions)					202.00	

Health Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	R	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0168	Period: From 01/01/2022	Worksheet D Part I	
				To 12/31/2022		
		Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col. 1 - co			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	r				-	
30. 00 ADULTS & PEDIATRICS	1, 517, 551	C	1, 517, 5	51 5, 544		
31. 00 INTENSIVE CARE UNIT	0			0 0		
32.00 CORONARY CARE UNI T	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVIDER - IPF	0	C		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	0	C		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30 through 199)	1, 517, 551		1, 517, 5	51 5, 544		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
	······································	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1		·	
30. 00 ADULTS & PEDIATRICS	878	240, 335	5			30.00
31. 00 INTENSIVE CARE UNIT	0	Ċ				31.00
32.00 CORONARY CARE UNIT	0	C				32.00
33.00 BURN INTENSIVE CARE UNIT	0	C				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0	C				34.00
40. 00 SUBPROVIDER - IPF	0	C				40.00
41. 00 SUBPROVIDER - IRF	0	c c				41.00
43. 00 NURSERY	0	c c				43.00
44.00 SKILLED NURSING FACILITY	0	c r				44.00
45. 00 NURSING FACILITY	0	C				45.00
200.00 Total (lines 30 through 199)	878	240, 335				200.00
	0,01	240, 333	1			1200.00

J	UTHERAN MUSCULOS				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	FAL COSTS	Provider C	CN: 15-0168	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/31/2023 9:1	pared: 3 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0.404.455		0.0117		450.400	
50. 00 O5000 OPERATING ROOM	3, 496, 155				158, 480	
51.00 O5100 RECOVERY ROOM	935, 150				26, 603	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	760				46	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	287, 706				8, 699	
54.01 03630 ULTRA SOUND	4	35, 516			2	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-			0	
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000		0	56.00
57.00 05700 CT SCAN	0	0			0	57.00
58.00 05800 MRI	0	0	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-			0	59.00
60. 00 06000 LABORATORY	1, 960	12, 539, 425			238	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.0000	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	0	0	0.00000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000		0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	56	689, 746			10	
66. 00 06600 PHYSI CAL THERAPY	1, 850, 596	44, 549, 115			34, 987	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	386	2, 237, 170			40	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 941	60, 945, 787	0. 00024	45 5, 173, 118	1, 267	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	421, 955	358, 560, 892	0. 00117	77 35, 624, 872	41, 930	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 746	44, 075, 355	0. 00056	2, 882, 430	1, 617	73.00
74.00 07400 RENAL DIALYSIS	0	83, 599	0.0000	33, 407	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0				0	75.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0			0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
91. 00 09100 EMERGENCY	0	0	0.0000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	471, 088	5, 872, 375	0. 08022	21 203, 628	16, 335	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
AL AN ANY AND ANY FUED ANY FOUND DENTED	0	l o	0. 00000	0 00	0	96.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0					
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0 0	0	97.00
		0			0	97.00 98.00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	LUTHERAN MUSCULOS			In Lie Period:	u of Form CMS-: Worksheet D	2552-10
AFFORTIONWENT OF INFATIENT ROOTINE SERVICE OTHER				From 01/01/2022 To 12/31/2022	Part III	epared: 3 am
		Title	e XVIII	Hospi tal	PPS	<u>o un</u>
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
UNDATIONT DOUTING OFDIVING ODOT OFNITEDO	1A	1.00	2A	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0	J		0	1 20 00
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	
31. 00 03100 I NTENSI VE CARE UNI T	0	0	1	0 0	0	
32. 00 03200 CORONARY CARE UNIT	0	U		0 0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT	0	U			0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	U		0	0	
40. 00 04000 SUBPROVI DER - I PF	0	U		0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	
43.00 04300 NURSERY	0	0		0 0	0	1 .0.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0		44.00
45. 00 04500 NURSI NG FACI LI TY	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		Per Diem (col.	Inpatient	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)		6.00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 54	4 0.00	878	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	-,		0/0	
		0		0.00	0	
		0	1		0	
33. 00 03300 BURN INTENSIVE CARE UNIT		U		0.00	-	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		U		0.00	0	
40. 00 04000 SUBPROVIDER - IPF	0	0		0.00	0	
11.00 04100 SUBPROVIDER - IRF	0	0		0.00	0	
43. 00 04300 NURSERY		0		0.00	0	
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	
45.00 04500 NURSING FACILITY		C		0.00	0	
200.00   Total (lines 30 through 199)		C	5, 54	4	878	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col.8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					31.00
	0					
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
	0					41.00
						1 12 00
43. 00 04300 NURSERY	0					
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0					43.00 44.00
43. 00 04300 NURSERY	-					

	Financial Systems L TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	DVICE OTHED DAS	S Provider CO	N. 15 0160	Do	eriod:	Worksheet D	2552-10
	TOWNENT OF TWPATTENT/OUTPATTENT ANGILLART SE COSTS	RVICE UTHER PAS		JN. 13-0108		om 01/01/2022	Part IV Date/Time Prej 5/31/2023 9:13	
			Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program		Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00		3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00		2.00		0/1	0.00	
50.00	05000 OPERATI NG ROOM	0	0 0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0			0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	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 OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	-		0	0	0	57.00
58.00	05800 MRI	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60,00
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	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00	06400 INTRAVENOUS 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	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	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	75.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0 0		0	0	0	77.00
	OUTPATIENT SERVICE 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	89.00
90.00	09000 CLI NI C	0			0	0	0	90.00
91.00	09100 EMERGENCY	0	-		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			0		0	92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
94.00 95.00	09500 AMBULANCE SERVICES		1		0	0	0	94.00
95.00 96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED				0	0	0	97.00
	09850 OTHER REIMBURSABLE COSTS				0	0	0	97.00
98.00								

	Financial Systems L IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	DVICE OTHED DAS	SKELETAL CENTER S Provider C		Peri od:	u of Form CMS-2 Worksheet D	2002 10
	H COSTS	NICE UTIER FAS	5 FIOVICEI C	GN. 15-0108	From 01/01/2022		
THROOD	11 00313				To 12/31/2022	Date/Time Pre	
						5/31/2023 9:1	<u>3 am</u>
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	6.00	7.00	instructions) 8.00	
	ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 297, 117, 961	0.000000	50.00
51.00	05100 RECOVERY ROOM	0			0 59, 958, 597	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 27, 359, 676	0. 000000	•
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 23, 537, 453	0. 000000	
54.01	03630 ULTRA SOUND	0	0		0 35, 516	0. 000000	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0.000000	•
57.00	05700 CT SCAN	0	0		0 0	0.000000	•
58.00	05800 MRI	0	0		0 0	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.000000	•
60.00	06000 LABORATORY	0	0		0 12, 539, 425	0.000000	•
60.01	06001 BLOOD LABORATORY	0	0		0 12,007,120	0.000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				°	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0. 000000	•
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	•
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	•
65.00	06500 RESPI RATORY THERAPY	0	0		0 689, 746	0.000000	•
66.00	06600 PHYSI CAL THERAPY	0	0		0 44, 549, 115	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	•
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 2, 237, 170	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 60, 945, 787	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 358, 560, 892	0.00000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 44, 075, 355	0.00000	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 83, 599	0. 000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	75.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.00000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	89.00
90.00	09000 CLINIC	0	0		0 0	0.00000	90.00
91.00	09100 EMERGENCY	0	0		0 0	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 5, 872, 375	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS		1	1			
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0. 000000	•
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	-		0 0	0. 000000	•
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0.00000	•
98.00 200.00	09850 OTHER REIMBURSABLE COSTS Total (lines 50 through 199)	0	0		0 0 937, 562, 667	0.00000	98.00 200.00

PPORTI ON	nancial Systems L MENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0168	Peri od:	Worksheet D	2552-10
HROUGH C					From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	pared:
			Title	XVIII	Hospi tal	5/31/2023 9:1 PPS	3 am
	Cost Center Description	Outpatient	Inpatient	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	onar goo	Costs (col.		Costs (col. 9	
		7)		x col. 10)	0	x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANC	CILLARY SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	12100	10100	
	DOO OPERATING ROOM	0. 000000	13, 468, 159		0 35, 479, 371	0	50.00
51.00 051	IOO RECOVERY ROOM	0. 000000	1, 705, 648		0 7, 442, 855	0	51.00
	200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
	BOO ANESTHESI OLOGY	0. 000000	1, 626, 011		0 2, 579, 651	0	53.00
	100 RADI OLOGY-DI AGNOSTI C	0. 000000			0 1, 557, 214	0	54.00
			711, 664			-	
	530 ULTRA SOUND	0. 000000	13, 580		0 0	0	54.0
	500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
6.00 056	500 RADI OI SOTOPE	0. 000000	0		0 0	0	56.0
7.00 057	700 CT SCAN	0. 000000	0		0 0	0	57.0
8.00 058	BOO MRI	0. 000000	0		0 0	0	58.0
9.00 059	200 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.0
	DOO LABORATORY	0. 000000	1, 524, 840		0 1, 356, 123	0	60.0
	001 BLOOD LABORATORY	0. 000000	1, 02 1, 010		0 0	0	60.0
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		0 0	0	
		0,000000	0		0	0	61.0
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
	BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
	100 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.0
5.00 065	500 RESPI RATORY THERAPY	0. 000000	120, 856		0 36, 048	0	65.0
6.00 066	500 PHYSI CAL THERAPY	0. 000000	842, 220		0 287, 808	0	66.0
7.00 067	00 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.0
8.00 068	BOO SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.0
	200 ELECTROCARDI OLOGY	0. 000000	229, 690		0 385, 520	0	69.0
	DOO ELECTROENCEPHALOGRAPHY	0. 000000	22,70,0		0 0	0	70.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 173, 118		0 6, 111, 126	0	71.0
						-	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	35, 624, 872		0 34, 743, 846	0	72.0
	BOO DRUGS CHARGED TO PATIENTS	0. 000000	2, 882, 430		0 4, 362, 722	0	73.0
	100 RENAL DI ALYSI S	0. 000000	33, 407		0 0	0	74.0
	500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.0
	700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.0
	PATIENT SERVICE COST CENTERS						
38.00 088	300 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
9.00 089	POO FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.0
0.00 090	DOO CLINIC	0. 000000	0		0 0	0	90.0
	IOO EMERGENCY	0.000000	0		0 0	0	91.0
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	203, 628		0 1, 136, 151	0	92.0
	IER REI MBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		1
	HONE PROGRAM DI ALYSI S	0.000000	0		0 0	0	94.00
	500 AMBULANCE SERVICES	0.000000	0		0	0	95.0
		0,000000	~			0	
	DOO DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.0
	700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.0
	350 OTHER REIMBURSABLE COSTS	0. 000000	0		0 0	0	98.0
200.00	Total (lines 50 through 199)		64, 160, 123	1	0 95, 478, 435	0	200.00

APPORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/31/2023 9:1	
			Title	2 XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From Worksheet C,	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
		Part I, col. 9	mst.)	Subject To	Subject To		
				Ded. & Coi ns	-		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
ANCI LL	ARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 096044	35, 479, 371		0 0	3, 407, 581	
	RECOVERY ROOM	0. 093353	7, 442, 855		0 0	694, 813	
	DELIVERY ROOM & LABOR ROOM	0. 000000	C		0 0	0	
	ANESTHESI OLOGY	0.003023	2, 579, 651		0 0	7, 798	
	RADI OLOGY-DI AGNOSTI C	0.059079	1, 557, 214	1	0 0	91, 999	
	ULTRA SOUND	0. 152607	0		0 0	0	
1 1	RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	
	RADI OI SOTOPE	0. 000000	0		0 0	0	
	CT SCAN	0.000000	0		0 0	0	
58.00 05800		0.000000	0		0 0	0	
	CARDI AC CATHETERI ZATI ON	0.000000	1 25 ( 122		0 0	0	
1 1		0.047258	1, 356, 123			64, 088	
1 1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000	C		0 0	0	60.01 61.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	C		0 0	0	
1 1	BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0 0	0	
	INTRAVENOUS THERAPY	0.000000	0		0 0	0	
	RESPI RATORY THERAPY	0.063186	36, 048		0 0	2, 278	
1 1	PHYSI CAL THERAPY	0. 185639	287, 808		0 0	53, 428	
1 1	OCCUPATIONAL THERAPY	0. 000000	207,000	1	0 0	00, 120	1
1 1	SPEECH PATHOLOGY	0.000000	0	1	0 0	0	•
	ELECTROCARDI OLOGY	0. 037882	385, 520	)	0 0	14,604	
70.00 07000	ELECTROENCEPHALOGRAPHY	0. 000000	C	1	0 0	0	1
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 019923	6, 111, 126		0 0	121, 752	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 077002	34, 743, 846		0 0	2, 675, 346	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 042137	4, 362, 722		0 521	183, 832	73.00
74.00 07400	RENAL DIALYSIS	0. 000993	C		0 0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
	ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
	TIENT SERVICE COST CENTERS			1			
	RURAL HEALTH CLINIC						88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER		_			_	89.00
	CLINIC	0.000000	0		0 0	0	
	EMERGENCY	0.000000	0		0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART	0. 442895	1, 136, 151		0 0	503, 196	92.00
	REIMBURSABLE COST CENTERS	0.000000			0 0		04 00
	HOME PROGRAM DI ALYSI S AMBULANCE SERVI CES	0. 000000 0. 000000			0 0		94.00 95.00
	DURABLE MEDICAL EQUIP-RENTED	0. 000000	C		0 0	0	
	DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	
	OTHER REIMBURSABLE COSTS	0.000000			0 0	0	
1 1	Subtotal (see instructions)	0.000000	95, 478, 435	5,00		7, 820, 715	
	Less PBP Clinic Lab. Services-Program		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3,00		,, 020, 713	201.00
	5				-		L0
	Only Charges						

51.00         05100         RECOVERY ROM         51.00         55.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00	Health Financial Systems	JTHERAN MUSCULOS	KELETAL CENTER	2	In Lie	u of Form CMS-	2552-10
Cost Center Description         Cost Reinbursed Reinbursed Subject To bod & Cost Reinbursed Subject To bod & Cost Subject To Subject	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0168	From 01/01/2022	Part V Date/Time Pre	
Cost Center Description         Cost Beinbursed Services         Cost Subject To Ded & Coins.         Cost Beinbursed Services         Cost Subject To Ded & Coins.           50.00         000000PERATING FORM Services         000000000000000000000000000000000000			Title	XVIII	Hospi tal	PPS	
Relimbursed Subject To Subject T							
Services	Cost Center Description						
Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)         Subject To Ded. & Coins. (see inst.)           0         0         0         0         0         0         0           0         0         0         0         0         0         0         0           0         0         0         0         0         0         0         0         0           1         00         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Ded. & Coins. (see inst.)         Ded. & Coins. (see inst.)           ANCILLARY SERVICE COST CENTERS         6.00         7.00           50.00         05000 (PERATING ROOM         0         0           52.00         05200 (PERATING ROOM         0         0           52.00         05200 (PELCENPR NOM & LABOR ROOM         0         0         0           52.00         05200 (PELCENPR NOM & LABOR ROOM         0         0         0           54.00         05400 (RADI CLOP")         0         0         0         55.00           55.00         05500 (RADI CLOP")         0         0         0         55.00							
(see Inst.)         (see Inst.)           6.00         7.00           50.00         05000 (PERATIN R ROM         0           51.00         05100 (PERATIN R ROM         0         0           52.00         05200 (PERATIN R ROM         0         0           52.00         05200 (PERATIN R ROM         0         0           53.00         05300 (ANESTHES) 0LOCY         0         0           53.00         05300 (ANESTHES) 0LOCY         0         0           54.01         03330 (UTRA SOUND         0         0           55.00         05500 (STGC) (CTRA)         0         0           56.00         05600 (RADIOISTOPE         0         0           57.00         05700 (CTSCAN         0         0           58.00         06800 (MRI         0         0         0           60.00         06800 (MRI         0         0         0           61.00         06800 (MRI         0         0         0           62.00         06200 (LABOATORY         236         0         60.00           63.00         06400 (LABOATORY         0         0         61.00           63.00         06400 (LABOATORY         0 <t< td=""><td></td><td></td><td>2</td><td></td><td></td><td></td><td></td></t<>			2				
INCLLARY SERVICE COST CENTERS         0         7.00           50.00         50000 OPERATING ROOM         0         0           51.00         51.00         50000 APESTRESI LOGY         0         0           52.00         50000 APESTRESI LOGY         0         0         53.00           53.00         53.00 APESTRESI LOGY         0         0         53.00           53.00         05300 APESTRESI LOGY         0         0         54.00           54.00         05400 RADI LOGY-THERAPEUTI C         0         0         55.00           55.00         05500 RADI OLOGY-THERAPEUTI C         0         0         55.00           56.00         05600 MRI         0         0         0         57.00           59.00         05700 CLABORATORY         256         0         66.00         66.00           0         0         0         0         66.00							
MNOLLARY SERVICE COST CENTERS           50.00         05000 PERATI RG XOM         0         0         0         50.00           51.00         05100 RECOVERY ROM         0         0         0         51.00           52.00         05200 RECOVERY ROM         0         0         0         53.00           53.00         05300 ANESTHESI DLOGY         0         0         0         53.00           55.00         05500 ANESTHESI DLOGY         0         0         54.01         55.00           55.00         05500 CT SCAN         0         0         0         55.00           56.00         05600 CT SCAN         0         0         0         57.00           57.00         05500 CT SCAN         0         0         0         58.00           59.00         05600 ARI         0         0         0         60.00           60.00         06000 LABORATORY         236         0         60.00         60.00           60.00         06300 BLOOD LABORATORY         0         0         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
50:00         55000 OPERATING ROOM         0         0         50:00         55:00         55:00         55:00         55:00         55:00         55:00         55:00         56:00	ANCILLARY SERVICE COST CENTERS	0.00		1			
51.00         05100         RECOVERY ROM         51.00         52.00         53.00         55.00         53.00         55.00         53.00         55.00         56.00         55.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00         56.00		0	0				50.00
52.00         05200         DEL/VERY ROM & LABOR ROM         0         0         52.00         53.00         55.00         56.00		-		1			51.00
53. 00     05300     AVESTHESI OLOGY     0     0       54. 00     64.00     64.00     54.00       54. 00     05.00     0550     0550       55. 00     0550     0550     0       57. 00     0570     0570     0570       57. 00     0570     0570     0570       57. 00     0570     0570     0570       57. 00     0570     0570     0570       57. 00     0570     0570     0570       57. 00     0570     0570     0570       58. 00     05800 MRI     0     0       00. 06000 LABORATORY     236     0     60.00       00. 06000 LABORATORY     236     0     60.00       00. 0500 BLODD STORING. PROCESSING & TRANS.     0     0     62.00       00. 06300 BLODD STORING. PROCESSING & TRANS.     0     0     64.00       00. 06300 BLODD STORING. PROCESSING & TRANS.     0     0     66.00       00. 06400 RESPIRATORY     0     0     66.00     66.00       66.00     06500 RESPIRATORY     0     0     66.00       66.00     06500 RESPIRATORY THERAPY     0     0     66.00       66.00     06500 RESPIRATORY THERAPY     0     0     67.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.01       03630       ULTRA SOUND       0       94.01       00       94.01       00       95.00       055.00       00       055.00       00       055.00       00       00       55.00       00       00       55.00       00       00       55.00       00       00       00       00       55.00	53. 00 05300 ANESTHESI OLOGY	0	0				53.00
55.00         OS500         RADIO LOGY-THERAPEUTI C         0         0         55.00	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56.00         OS600         RADIO ISOTOPE         0         56.00         S5.00	54.01 03630 ULTRA SOUND	0	0				54.01
57.00         05700 (CT SCAN         0         0         57.00         57.00         57.00         57.00         57.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         59.00         58.00         59.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         63.00         66.00         67.00 <t< td=""><td>55. 00 05500 RADI OLOGY-THERAPEUTI C</td><td>0</td><td>0</td><td></td><td></td><td></td><td>55.00</td></t<>	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
58.00         OSB00 MRI         0         0         58.00         S9.00         S9.	56. 00 05600 RADI OI SOTOPE	0	0				56.00
59.00         05900         CARDIAC CATHETERIZATION         0 <t< td=""><td>57.00 05700 CT SCAN</td><td>0</td><td>0</td><td></td><td></td><td></td><td>57.00</td></t<>	57.00 05700 CT SCAN	0	0				57.00
60.00         06000         LABORATORY         236         0         60.00         62.00         60.00         62.00         60.00         62.00         63.00         63.00         63.00         63.00         63.00         63.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         64.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         68.00         68.00         68.00         69.00         68.00         69.00         69.00         69.00         69.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00		0	0				58.00
60.01         06001         BLOOD LABORATORY         0         0           61.00         06100         PBP CLINI CAL LAB SERVICES-PRGM ONLY         0         61.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0           64.00         06400         INTRAVENUS THERAPY         0         0           65.00         06500         OCUDATIONAL THERAPY         0         0           66.00         06600         OCUDATIONAL THERAPY         0         0           67.00         06700         OCUDATIONAL THERAPY         0         0         66.00           66.00         06600         PECH PATHOLOGY         0         0         66.00           66.00         06000 SPECH PATHOLOGY         0         0         69.00         69.00           71.00         07000 ELECTROENCEPHALGGRAPHY         0         0         71.00         71.00           72.00         07200 IMPL         DEV. CHARGED TO PATIENTS         0         0         72.00           73.00         07300 DRUGS CHARGED TO PATIENTS         0         0         73.00         73.00	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
61.00       06100       PBP CLINICAL LAB SERVICES-PROM ONLY       0       61.00         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0         64.00       06400       INTRAVENOUS THERAPY       0       0       63.00         65.00       06500 RESPIRATORY THERAPY       0       0       0       66.00         66.00       06600 PHYSICAL THERAPY       0       0       0       66.00       66.00         66.00       06600 SPEECH PATHOLOCY       0       0       0       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       69.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       71.00       71.00       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       75.00       75.00       75.00       75.00       75.00       75		236		•			60.00
62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         62.00         62.00         62.00         63.00         62.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         63.00         64.00         64.00         64.00         64.00         64.00         64.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00		0	0				60.01
63:00       66:00       100D STORING, PROCESSING & TRANS.       0       63:00       63:00         64:00       06400       INTRAVENOUS THERAPY       0       0       64:00       66:00         65:00       06600       PRSPIRATORY THERAPY       0       0       66:00       66:00         66:00       06000       PRSPIRATORY THERAPY       0       0       66:00       66:00         67:00       07:00       0000       0       0       66:00       66:00       66:00         68:00       06800       SPEECH PATHOLOGY       0       0       0       68:00       68:00       69:00       0       68:00       69:00       0       0       69:00       0       69:00       0		-					61.00
64.00       06400       INTRAVENOUS THERAPY       0       0       64.00       65.00       65.00       65.00       66.00       67.00       68.00       68.00       68.00       68.00       69.00       69.00       69.00       69.00       69.00       69.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       71.00       71.00       70.00       72.00       73.00       70.00       74.00       73.00       73.00       73.00       73.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00		S S		•			1
65.00       66500       RESPIRATORY THERAPY       0       0       66.00       67.00       67.00       67.00       67.00       67.00       67.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       75.00       74.00       75.00       74.00       75.00       74.00		-		•			1
66.00       06600       PHYSI CAL THERAPY       0       0       66.00       66.00       67.00       67.00       67.00       67.00       67.00       68.00       68.00       68.00       68.00       66.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       68.00       69.00       70.00       70.00       69.00       70.00       70.00       70.00       70.00       70.00       70.00       71.00       71.00       72.00       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       70.00       74.00       75.00       74.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00		S S		•			1
67.00       06700       OCCUPATIONAL THERAPY       0       0         68.00       06800       SPECH PATHOLOGY       0       0         69.00       06900       ELECTROCARDIOLOGY       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0         72.00       77200       IMPL. DEV. CHARGED TO PATIENTS       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00         73.00       07300       RNUGS CHARGED TO PATIENTS       0       0       74.00       74.00         75.00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       75.00       77.00         007700       ALLOGENEIC HSCT ACQUISITION       0       0       0       74.00       74.00         00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       0       74.00       74.00         00       08900       FEDERALLY QUALIFIED HEALTH CENTER       88.00       808.00       89.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.0		0		•			
68.00       06800       SPEECH PATHOLOGY       0       0       68.00       69.00       70.00       70.00       71.00       71.00       71.00       71.00       71.00       71.00       73.00       73.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00		0					1
69.00       06900       ELECTROCARDIOLOGY       0       0       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       73.00       73.00         74.00       07500       ASC (NON-DISTINCT PART)       0       0       74.00       77.00       0       97.00       99.00 </td <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td> <td>1</td>		0	-				1
70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       REVAGED TO PATI ENTS       0       22       73.00         74.00       07400       RENAL DI ALYSI S       0       0       74.00         75.00       07500       ALCOENFLIC HSCT ACQUISITION       0       0       75.00         00       07700       ALLOGENEIC C HSCT ACQUISITION       0       0       75.00         00       08800       RURAL HEALTH CLINIC       88.00       88.00       89.00         88.00       08800       RURAL HEALTH CLINIC       88.00       99.00       00       0       90.00         90.00       09000       CLINIC       0       0       0       90.00       9200       00       9200       00       9200       00       9200       00       9200       00       9200       9200       9200       9200       9200       9200       9200       9200       9200       9200       9200       9200		0		•			
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       71.00       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00       72.00         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       73.00       73.00         74.00       07400       RENAL DI ALYSIS       0       0       74.00       75.00		0					1
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0         73.00       07300       DRUGS CHARGED TO PATIENTS       0       22         74.00       07400       RENAL DIALYSIS       0       0         75.00       07500       ASC (NON-DISTINCT PART)       0       0         77.00       07700       ALLOGENEIC HSCT ACQUISITION       0       0         0000700       ALLOGENEIC HSCT ACQUISITION       0       0       77.00         0000700       ALLOGENEIC HSCT ACQUISITION       0       0       77.00         0000700       ALLOGENEIC HSCT ACQUISITION       0       0       77.00         0000700       RURAL HEALTH CLINIC       88.00       88.00       88.00         90.00       09900       CLINIC       0       0       90.00         90.00       09000       CLINIC       0       0       90.00         91.00       09100       EMEGENCY       0       0       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART       0       0       92.00         94.00       09400       HOME PROGRAM DIALYSIS       0       0       94.00         94.00       09400       MBUBANCE SERVICES		0		1			1
73.00       07300       DRUGS CHARGED TO PATIENTS       0       22       73.00         74.00       07400       RENAL DIALYSIS       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       75.00         00700       ALLOGENEIC INSCT ACQUISITION       0       0       75.00       75.00         01701       DUTPATIENT SERVICE COST CENTERS       88.00       08900       RURAL HEALTH CLINIC       88.00         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       88.00       90.00       90.00       90.00       90.00       90.00       90.00       91.00       90.00       91.00       92.00<		0					1
74.00       07400       RENAL DI ALYSI S       0       0       74.00         75.00       07500       ASC (NON-DI STI NCT PART)       0       0       75.00         77.00       ALLOGENEI C HSCT ACQUI SI TI ON       0       0       75.00         000TPATI ENT SERVICE COST CENTERS       88.00       08800       RURAL HEALTH CLI NI C       88.00         88.00       08900       FEDERALLY QUALI FI ED HEALTH CENTER       88.00       90.00       90.00         90.00       09000       CLI NI C       0       0       90.00         91.00       O9100       EMERGENCY       0       0       90.00         92.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       91.00         92.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       92.00         94.00       09400       HOME PROGRAM DI ALYSI S       0       0       94.00         95.00       09500       AMBULANCE SERVICES       0       95.00       95.00         95.00       09500       MBRALE MEDI CAL EQUI P-RENTED       0       0       95.00         96.00       09600       DURABLE MEDI CAL EQUI P-SOLD       0       0       97.00		0		1			
75.00       07500       ASC (NON-DI STINCT PART)       0       0       75.00       75.00         77.00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       77.00         0UTPATI ENT SERVICE COST CENTERS       88.00       08800       RURAL HEALTH CLINIC       88.00         88.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       88.00       88.00         90.00       09900       FEDERALLY QUALIFIED HEALTH CENTER       89.00       90.00         91.00       09100       EMERGENCY       0       0       90.00         92.00       095ERVATION BEDS (NON-DISTINCT PART       0       0       91.00         92.00       095EQU OBSERVATION BEDS (NON-DISTINCT PART       0       0       92.00         04.00       09400       HOME PROGRAM DIALYSIS       0       0       94.00         94.00       09400       HOME PROGRAM DIALYSIS       0       0       95.00         95.00       09500       MBULANCE SERVICES       0       96.00       97.00         96.00       09600       DURABLE MEDICAL EQUI P-SOLD       0       0       96.00         97.00       09700       DURABLE MEDICAL EQUI P-SOLD       0       0       98.00       98.00		0					74.00
77.00       07700       ALLOGENEIC HSCT ACQUISITION       0       0       77.00         OUTPATIENT SERVICE COST CENTERS       88.00       08800       RURAL HEALTH CLINIC       88.00         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       88.00       90.00         90.00       09000       CLINIC       0       0       90.00         91.00       09100       EMERGENCY       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0       92.00         094.00       HOME PROGRAM DI ALYSIS       0       0       92.00       94.00       95.00         94.00       09400       HOME PROGRAM DI ALYSIS       0       0       94.00       95.00         95.00       09500       AMBULANCE SERVICES       0       0       95.00       95.00         96.00       09600       DURABLE MEDICAL EQUI P-RENTED       0       0       96.00       97.00         97.00       09700       DURABLE MEDICAL EQUI P-SOLD       0       0       98.00       98.00         90.00       Subtotal (see instructions)       236       222       200.00       201.00       201.00         0       Urarge		0	0				75.00
88.00       08800       RURAL HEALTH CLINIC       88.00         89.00       08900       FEDERALLY OUALI FIED HEALTH CENTER       89.00         90.00       09000       CLINIC       0       0         91.00       09100       EMERGENCY       0       0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       0         01HER       REIMBURSABLE       COST CENTERS       92.00       92.00         09400       HOME PROGRAM DIALYSIS       0       0       92.00         95.00       09500       AMBULANCE SERVICES       0       95.00         96.00       09600       DURABLE MEDICAL EQUIP-RENTED       0       0         97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0         98.00       09850       OTHER REI MBURSABLE COSTS       0       0         98.00       09850       Subtotal (see instructions)       236       22       200.00         201.00       Less PBP Clinic Lab. Services-Program       0       0       201.00       201.00		0	0				77.00
89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       89.00         90.00       09000       CLINIC       0       90.00         91.00       09100       EMERGENCY       0       0         92.00       09200       DSERVATION BEDS (NON-DISTINCT PART       0       0         94.00       09400       HOME PROGRAM DIALYSIS       0       0       91.00         95.00       09500       AMBULANCE SERVICES       0       95.00       95.00       95.00       95.00       96.00       95.00       95.00       96.00       96.00       97.00       97.00       97.00       97.00       98.00       0       0       96.00       98.00	OUTPATIENT SERVICE COST CENTERS						
90.00       09000       CLINIC       0       0       90.00         91.00       09100       EMERGENCY       0       0       91.00         92.00       09200 (DBSERVATION BEDS (NON-DISTINCT PART)       0       0       91.00       92.00         0THER       REIMBURSABLE       COST CENTERS       92.00       94.00       94.00       95.00         94.00       09400       HOME       PROGRAM DI ALYSIS       0       0       94.00         95.00       09500       AMBULANCE SERVICES       0       95.00       95.00       95.00       95.00       96.00       98.00       98.00<	88.00 08800 RURAL HEALTH CLINIC						88.00
91.00       09100       EMERGENCY       0       0       91.00       92.00         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92.00         0THER       REI MBURSABLE       COST CENTERS       0       0       92.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       94.00       95.00       0       94.00       95.00       95.00       95.00       96.00       97.00       97.00       0       0       95.00       96.00       96.00       96.00       96.00       96.00       96.00       96.00       97.00       98.00       09850       0THER REI MBURSABLE COSTS       0       0       97.00       98.00       200.00       200.00       201.01       (see instructions)       236       222       200.00       201.00       0	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0         0         92.00           OTHER         REIMBURSABLE COST CENTERS         0         0         0         94.00         9400         HOME PROGRAM DI ALYSI S         0         0         94.00         94.00         95.00         09500         AMBULANCE SERVICES         0         0         95.00         95.00         96.00         97.00         0         0         95.00         96.00         0         96.00         97.00         97.00         07000         DURABLE MEDI CAL EQUI P-RENTED         0         0         96.00         97.00         98.00         09850         OTHER REI MBURSABLE COSTS         0         0         97.00         97.00         98.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00         Less PBP Clinic Lab. Services-Program         0         201.00         201.00         0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         2	90. 00 09000 CLINIC	0	0				90.00
OTHER         REIMBURSABLE         COST         CENTERS           94.00         09400         HOME         PROGRAM         DI ALYSI S         0         0         94.00         95.00         95.00         09500         AMBULANCE         SERVI CES         0         95.00         96.00         96.00         96.00         96.00         97.00         97.00         98.00         9850         0 HER         98.00				1			91.00
94. 00         09400         HOME         PROGRAM         DI ALYSI S         0         0         94. 00         94. 00         94. 00         94. 00         94. 00         94. 00         94. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         95. 00         96. 00         96. 00         96. 00         96. 00         96. 00         96. 00         96. 00         97. 00         0         0         96. 00         97. 00         0         96. 00         97. 00         0         97. 00         0         98. 00         09850         0 THER REI MBURSABLE COSTS         0         0         98. 00<		0	0				92.00
95.00       09500       AMBULANCE SERVICES       0       95.00       95.00         96.00       09600       DURABLE MEDICAL EQUIP-RENTED       0       0       96.00         97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       97.00       97.00         98.00       09850       OTHER REI MBURSABLE COSTS       0       0       98.00       98.00         200.00       Subtotal (see instructions)       236       22       200.00       201.00       0       01.9 Charges       0       0		1 1		1			
96.00         09600         DURABLE MEDICAL EQUIP-RENTED         0         0         96.00         97.00         97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0         0         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         97.00         98.00		-	0				1
97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0         97.00           98.00         09850         OTHER REI MBURSABLE COSTS         0         0         98.00           200.00         Subtotal (see instructions)         236         22         200.00         201.00           201.00         Less PBP Clinic Lab. Services-Program         0         0         201.00         0			-				
98.00098500THER RELIMBURSABLE COSTS0098.00200.00Subtotal (see instructions)23622200.00201.00Less PBP Clinic Lab. Services-Program0201.000nl y Charges000							
200.00Subtotal (see instructions)23622200.00201.00Less PBP Clinic Lab. Services-Program0201.00201.000nly Charges0000		-					
201.00     Less PBP Clinic Lab. Services-Program     0     201.00       Only Charges     0     0				1			
Only Charges		1	22				
		0					201.00
	202.00 Net Charges (line 200 - line 201)	236	22				202.00

APPORTIONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0168	Period: From 01/01/2022	Worksheet D Part V	2552-10
					To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
			Ti tl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins (see inst.)			
		1.00	2.00	3.00	(see inst.) 4.00	5.00	
ANCI L	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	OPERATING ROOM	0.096044	0		0 1, 163, 119	0	50.00
51.00 05100	RECOVERY ROOM	0. 093353	0		0 267, 030	0	51.00
52.00 05200	D DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300	ANESTHESI OLOGY	0.003023	0		0 116, 876	0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0.059079	0		0 91, 586	0	54.00
54.01 03630	ULTRA SOUND	0. 152607	0		0 0	0	54.01
55.00 05500	RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56.00 05600	RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
	DCT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800		0. 000000	0		0 0	0	58.00
	CARDIAC CATHETERIZATION	0. 000000	0		0 0	0	59.00
	DLABORATORY	0. 047258	0		0 29, 441	0	
	1 BLOOD LABORATORY	0. 000000	0		0 0	0	
	D PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0		0 0	0	
	D BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0 0	0	
	DINTRAVENOUS THERAPY	0.00000	0		0 0	0	
	RESPIRATORY THERAPY	0.063186	0		0 0	0	
	D PHYSI CAL THERAPY	0. 185639	0		0 149, 373	0	
	O OCCUPATIONAL THERAPY	0. 000000	0		0 0	0	
	SPEECH PATHOLOGY	0.000000	0		0 0 0 3.864	0	
	D ELECTROCARDI OLOGY	0. 037882 0. 000000	0		0 3,864 0 0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 019923	0		0 182, 510	0	
	DIMPL. DEV. CHARGED TO PATIENTS	0. 077002	0		0 521, 244	0	
	D DRUGS CHARGED TO PATIENTS	0. 042137	0		0 510, 891	0	
	RENAL DIALYSIS	0. 000993	0		0 0	0	
	ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
	ALLOGENEIC HSCT ACQUISITION	0.000000	0		0 0	0	77.00
OUTPA	ATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC						88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00 09000		0. 000000	0		0 0	0	90.00
91.00 09100	EMERGENCY	0. 000000	0		0 0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART	0. 442895	0		0 12, 780	0	92.00
	R REIMBURSABLE COST CENTERS	· · ·		1			
	D HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
	DAMBULANCE SERVICES	0.000000	0		0		95.00
	D DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
	D DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
98.00 09850	OTHER REIMBURSABLE COSTS	0. 000000	0		0 0	0	
000 00	Subtotal (see instructions)	1	0		0 3, 048, 714	0	200.00
200.00					0		001 00
200. 00 201. 00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pro 5/31/2023 9:	
	_	Titl	e XIX	Hospi tal	Cost	_
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS		-				
. 00 05000 OPERATING ROOM	0	111, 711				50.0
. 00 05100 RECOVERY ROOM	0	24, 928				51.0
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. (
. 00 05300 ANESTHESI OLOGY	0	353				53.0
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 411				54.0
. 01 03630 ULTRA SOUND	0	0	1			54.0
. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
. 00 05600 RADI OI SOTOPE	0	0				56.
. 00 05700 CT SCAN	0	0				57.
. 00   05800 MRI	0	0				57.
	u u					
. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.
. 00 06000 LABORATORY	0	1, 391				60.
. 01 06001 BLOOD LABORATORY	0	0				60.
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.
. 00 06400 INTRAVENOUS THERAPY	0	0				64.
. 00 06500 RESPI RATORY THERAPY	0	0				65.
. 00 06600 PHYSI CAL THERAPY	0	27, 729				66.
. 00 06700 OCCUPATIONAL THERAPY	0	0				67.
. 00 06800 SPEECH PATHOLOGY	0	0				68.
. 00 06900 ELECTROCARDI OLOGY	0	146				69.
. 00 07000 ELECTROENCEPHALOGRAPHY	0		1			70.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 636				71.
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		1			72.
. 00 07300 DRUGS CHARGED TO PATIENTS	0	21, 527				73.
. 00 07400 RENAL DIALYSIS	0					74.
. 00 07500 ASC (NON-DI STINCT PART)	0	-	•			75.
. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	-	•			77.
OUTPATIENT SERVICE COST CENTERS	0	0				- '''
						88.
						89.
. 00 09000 CLINIC	0	-				90.
. 00 09100 EMERGENCY	0	-				91.
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	5, 660				92.
OTHER REIMBURSABLE COST CENTERS	-	-	1			
. 00 09400 HOME PROGRAM DI ALYSI S	0	-				94.
. 00 09500 AMBULANCE SERVICES	0					95.
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	-	•			96.
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-				97.
. 00 09850 OTHER REIMBURSABLE COSTS	0	0				98.
0.00 Subtotal (see instructions)	0	242, 629				200.
1.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
2.00 Net Charges (line 200 - line 201)	0	242, 629				202.

Health Financial Systems

LUTHERAN	MUSCULOSKEI	_ETAL	CENT	ER

In Lieu of Form CMS-2552-10

Ith Financial Systems LUTHERAN MUSCULOSK	ELETAL CENTER	In Lie	u of Form CMS-2	255
IPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od:	Worksheet D-1	
		From 01/01/2022 To 12/31/2022	Date/Time Pre	nar
		10 12/31/2022	5/31/2023 9:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS			E E44	1 1
0 Inpatient days (including private room days and swing-bed day 0 Inpatient days (including private room days, excluding swing-			5, 544 5, 544	
0 Private room days (excluding swing-bed and observation bed da		civato room dave	0,544	
do not complete this line.	ays). If you have only pi	i vate i ooni uays,	0	
00 Semi-private room days (excluding swing-bed and observation b	bed days)		3, 823	4
0 Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
reporting period	, , , , , , , , , , , , , , , , , , ,			
00 Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
reporting period (if calendar year, enter 0 on this line)				
10 Total swing-bed NF type inpatient days (including private roo	om days) through Decembei	r 31 of the cost	0	
reporting period				
Total swing-bed NF type inpatient days (including private roo	om days) after December (	31 of the cost	0	8
reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1	to the Drogram (aveluding	a cwing had and	878	Ģ
newborn days) (see instructions)		y swilly-bed allu	0/0	
00 Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private u	room days)	0	10
through December 31 of the cost reporting period (see instruct				
00 Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
December 31 of the cost reporting period (if calendar year, e				
00 Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	te room days)	0	12
through December 31 of the cost reporting period		h		1 1
00 Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00 Medically necessary private room days applicable to the Progr			0	14
00 Total nursery days (title V or XIX only)	Tam (excluding swing-bed	uays)	0	
00 Nursery days (title V or XIX only)			0	
SWI NG BED ADJUSTMENT				
00 Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17
reporting period				
00 Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
reporting period		6 +b+	0.00	1 10
00 Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	
00 Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20
reporting period			0.00	2
00 Total general inpatient routine service cost (see instruction	ns)		8, 378, 289	2
00 Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost report	ting period (line	0	22
5 x line 17)				
00 Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
x line 18)				
00 Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
00 Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
x line 20)			Ŭ	1 2
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, 378, 289	2
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00 General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
00 Private room charges (excluding swing-bed charges)			0	
00 Semi-private room charges (excluding swing-bed charges)			0	
00 General inpatient routine service cost/charge ratio (line 27	÷ TIne 28)		0.000000	
00 Average private room per diem charge (line 29 ÷ line 3) 00 Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00 Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
00 Average per diem private room cost differential (line 34 x li			0.00	
00 Private room cost differential adjustment (line 3 x line 35)	- /		0.00	
00 General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 378, 289	
27 minus line 36)	·			
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			-	
00 Adjusted general inpatient routine service cost per diem (see			1, 511. 24	
00 Program general inpatient routine service cost (line 9 x line			1, 326, 869	
00 Medically necessary private room cost applicable to the Progr	, , , , , , , , , , , , , , , , , , , ,		0	
00 Total Program general inpatient routine service cost (line 39	$Q \perp line I(0)$		1, 326, 869	1 1

	Financial Systems LL ATION OF INPATIENT OPERATING COST	ITHERAN MUSCULOSKE	ELETAL CENTER		In Li Period:	ieu of Form CMS- Worksheet D-	
COMPO				N. 15 0100	From 01/01/202 To 12/31/202	22	epared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	Total patient Days[	Average Pe Diem (col. 1 col. 2)		S Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.	00	0 (	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0	00	0 0	43.00
44.00	CORONARY CARE UNIT	0	0		00		44.00
45.00	BURN INTENSIVE CARE UNIT	0	0		00	-	45.00
46.00	SURGI CAL INTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECIFY)	0	0	0.	00	0	46.00
47.00	Cost Center Description		I				47.00
48.00	Program inpatient ancillary service cost (Wk		Line 200)			1.00	7 48.00
48.00	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)		48.00
49.00	Total Program inpatient costs (sum of lines				. ,	6, 131, 336	6 49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine se	rvices (from	Wkst D si	m of Parts I an	d 240, 335	5 50.00
30.00				WK31. D, 30		240, 330	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fro	om Wkst. D,	sum of Parts II	290, 254	4 51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				530, 589	52.00
53.00	Total Program inpatient operating cost exclu	ding capital rela	ted, non-phys	sician anest	hetist, and	5, 600, 74	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					(	54.00
55.00	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55	.01, and 55.02)					56.00
57.00	Difference between adjusted inpatient operat	ing cost and targ	et amount (li	ne 56 minus	iline 53)		57.00
58.00 59.00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from t	he cost repor	rtina period	l endi ng 1996.	0.00	58.00       59.00
	updated and compounded by the market basket)			0.1	0		
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year co	ost 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 the	amount by wh	nich operati	ng costs (İine	(	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					(	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)				63.00
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docomb	or 21 of the	cost roport	ing pariod (Saa		64.00
04.00	instructions) (title XVIII only)	ts through becenib		cost report	ing period (see		04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the co	ost reportir	ng period (See	(	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65	5)(title XVI	<pre>II only); for</pre>	0	66.00
(7.00	CAH, see instructions						
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through D	ecember 31 of	f the cost r	reporting period		67.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of t	the cost rep	orting period	(	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)			69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID C	ONLY			
70.00 71.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	2		•	)		70.00
72.00	Program routine service cost (line 9 x line			<b>_</b> )			72.00
73.00	Medically necessary private room cost applic			ne 35)			73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet B.	Part II, column		74.00
	26, line 45)			· · · · · ·			
76.00 77.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for exces						79.00
80.00 81.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		i i i mi tati on	(IINe /8 MI	nus i ne 79)		80.00 81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82.00
83.00 84.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in						83.00 84.00
84.00 85.00	Utilization review - physician compensation		)				84.00
86.00	Total Program inpatient operating costs (sum	of lines 83 thro					86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions					1, 72	1 87.00
88.00	Adjusted general inpatient routine cost per		ine 2)			1, 511. 24	4 88.00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 600, 844	4 89.00

Health Financial Systems LU	THERAN MUSCULOS	SKELETAL CENTER	R	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 517, 551	8, 378, 289	0. 18112	9 2, 600, 844	471, 088	90.00
91.00 Nursing Program cost	0	8, 378, 289	0.00000	0 2, 600, 844	0	91.00
92.00 Allied health cost	0	8, 378, 289	0.00000	0 2, 600, 844	0	92.00
93.00 All other Medical Education	0	8, 378, 289	0. 00000			93.00

LUTHERAN	MUSCULOSKEI	_ETAL	CENT	ER

In Lieu of Form CMS-2552-10

lear th	Financial Systems LUTHERAN MUSCULOSK	CELETAL CENTER	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0168	Peri od:	Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared.
			10 12/31/2022	5/31/2023 9:1	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		5, 544	1.0
2.00	Inpatient days (including private room days and swing sed day Inpatient days (including private room days, excluding swing			5, 544	
3.00	Private room days (excluding swing-bed and observation bed d		rivate room days,	0	
	do not complete this line.	5 . 5 . 5 .	<b>J</b>		
4.00	Semi-private room days (excluding swing-bed and observation			3, 823	
5.00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decemb	er 31 of the cost	0	5.0
( 00	reporting period	and days) ofter December	21 of the east	0	1.0
6.00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oun days) after becember	31 OF the Cost	0	6.0
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7.0
	reporting period			-	
8.00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	327	9.0
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	oply (including privato	room dave)	0	10.0
10.00	through December 31 of the cost reporting period (see instru		room days)	0	10.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.0
	December 31 of the cost reporting period (if calendar year,		•		
12.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	12.0
12 00	through December 31 of the cost reporting period	IV only (including prive	ta raam dava)	0	12 0
13.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13. C
14.00	Medically necessary private room days applicable to the Prog			0	14.0
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16. C
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17. C
10 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	and often December 21 of	the east	0.00	18.0
16.00	reporting period	ces al tel December 31 01	the cost	0.00	10.0
19.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	19.0
	reporting period	5			
20. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20.0
04 00	reporting period	、 、		0 070 000	04.0
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decem		ting pariod (line	8, 378, 289 0	
22.00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22.0
23.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23.0
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24.0
25 00	7 x line 19)			0	25 0
∠ɔ. UU	Swing-bed cost applicable to NF type services after December x line 20)	si ui the cost reportin	y perioa (iine 8	0	25. C
26.00	Total swing-bed cost (see instructions)			0	26.0
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 378, 289	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ ITNE 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
	Average per diem private room cost differential (line 34 x l		/	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	8, 378, 289	37.0
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1 511 24	20 0
	Adjusted general inpatient routine service cost per diem (se	-		1, 511. 24 494, 175	
	Prodram deneral innatient rolltine service cost (line y v inn				
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog	-		494, 175	

	Financial Systems LU ATION OF INPATIENT OPERATING COST	THERAN MUSCULOSK	ELETAL CENTER		In Lie Period:	eu of Form CMS- Worksheet D-1	
					From 01/01/2022 To 12/31/2022	2	epared:
	Cost Center Description	Total Inpatient Costl	Total	e XIX Average Pe Diem (col. 1 col. 2)		Cost Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.00
	Intensive Care Type Inpatient Hospital Units						
43.00 44.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	0		00 00		) 43.00 ) 44.00
45.00	BURN INTENSIVE CARE UNIT	0	0		00 0		45.00
46.00 47.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	U	0	0.	00 0		46.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks					88, 155	
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines a				, column 1)	582, 330	48.01 49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing c	orvicos (from	What D au	m of Darte L and		50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines !					(	
53.00	Total Program inpatient operating cost excludimedical education costs (line 49 minus line 9		ated, non-phy	si ci an anest	netrst, and	(	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54.00
55.00	Target amount per discharge					0.00	55.00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55.	01, and 55.02)				0	56.00
57.00 58.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (I	ine 56 minus	line 53)		
59.00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	59.00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year c	ost report,	updated by the	0.00	60.00
61.00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ser of 50% of th	e amount by w	hich operati	ng costs (line	(	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % or	the target am	ount (line 5	6), otherwise		
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			cost report	ing period (See		0 64.00
	instructions)(title XVIII only)	5		•	51 (		
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reportin	g period (See		0 65.00
66.00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (line 6	4 plus line 6	5)(title XVI	<pre>II only); for</pre>	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost r	eporting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost rep	orting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (I	ine 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				)		70.00
71.00	Adjusted general inpatient routine service co				)		71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applica		(line 14 x li	ne 35)			72.00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient ( 26, line 45)	routine service	costs (from W	orksheet B,	Part II, column		75.00
76.00	Per diem capital -related costs (line 75 ÷ lin						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00 78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 70)		79.00 80.00
81.00	Inpatient routine service cost per diem limi		st frim tation		nus i ne 79)		81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (						82.00 83.00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85.00 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	3/			•   •	
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			1, 721 1, 511. 24	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				2, 600, 844	4 89.00

Health Financial Systems LL	THERAN MUSCULOS	SKELETAL CENTER	2	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 517, 551	8, 378, 289	0. 18112	9 2, 600, 844	471, 088	90.00
91.00 Nursing Program cost	0	8, 378, 289	0.00000	2, 600, 844	0	91.00
92.00 Allied health cost	0	8, 378, 289	0.00000	2, 600, 844	0	92.00
93.00 All other Medical Education	0	8, 378, 289	0.00000	2, 600, 844	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0168	Peri od:	Worksheet D-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
	Titl∈	e XVIII	Hospi tal	PPS	5 8
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	-
00 03000 ADULTS & PEDI ATRI CS		1	1, 912, 926		30
00 03100 I NTENSI VE CARE UNI T			0		31
00 03200 CORONARY CARE UNIT			0		32
00 03300 BURN INTENSIVE CARE UNIT			0		33
00 03400 SURGICAL INTENSIVE CARE UNIT			0		34
00 04000 SUBPROVIDER - IPF			0		40
00 04100 SUBPROVI DER – I RF			0		41
00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS		0.00/0		1 000 50/	1
00 05000 OPERATING ROOM		0.0960		1, 293, 536	
00 05100 RECOVERY ROOM 00 05200 DELIVERY ROOM & LABOR ROOM		0.0933		159, 227	51
00 05300 ANESTHESI OLOGY		0.0000		0 4, 915	
00 05400 RADI OLOGY-DI AGNOSTI C		0.0030		42, 044	54
01 03630 ULTRA SOUND		0. 1526		2,072	
00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	55
00 05600 RADI OI SOTOPE		0.0000		0	56
00 05700 CT SCAN		0.0000		0	57
00 05800 MRI		0.0000		0	58
00 05900 CARDI AC CATHETERI ZATI ON		0.0000	00 0	0	59
00 06000 LABORATORY		0.0472	58 1, 524, 840	72, 061	60
01 06001 BLOOD LABORATORY		0.0000	00 0	0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	00 0	0	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	62
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	63
00 06400 I NTRAVENOUS THERAPY		0.0000		0	64
00 06500 RESPI RATORY THERAPY		0.0631		7,636	
00 06600 PHYSICAL THERAPY		0. 1856		156, 349	
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY		0.0000		0	67
00 06900 ELECTROCARDI OLOGY		0.0378		8, 701	69
00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0,701	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0199		103, 064	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0770		2, 743, 186	
00 07300 DRUGS CHARGED TO PATIENTS		0. 0421		121, 457	
00 07400 RENAL DI ALYSI S		0.0009	93 33, 407	33	74
00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00 0	0	77
OUTPATI ENT SERVI CE COST CENTERS		1			
00 08800 RURAL HEALTH CLINIC		0.0000		0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89
		0.0000		0	90
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 0000		90, 186	91
OTHER REIMBURSABLE COST CENTERS		0.4420	203, 020	70, 100	174
00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94
00 09500 AMBULANCE SERVICES		0.0000	0	0	95
00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	96
00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
00 09850 OTHER REI MBURSABLE COSTS		0.0000		0	98
D. 00 Total (sum of lines 50 through 94 and 96 through 98)			64, 160, 123	4, 804, 467	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	,	201
2.00 Net charges (line 200 minus line 201)		1	64, 160, 123		202

PATIENT ANCILLARY SERVICE COST APPO	RTIONMENT	Provider C	CN: 15-0168	Peri od:	Worksheet D-3	3
				From 01/01/2022	Data (Time Dra	
				To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
		Titl	e XIX	Hospi tal	Cost	<u> </u>
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	+
INPATIENT ROUTINE SERVICE COST	CENTERS		1.00	2.00	5.00	
. 00 03000 ADULTS & PEDIATRICS				70, 239		30
. 00 03100 INTENSIVE CARE UNIT				0		31
. 00 03200 CORONARY CARE UNI T				0		32
00 03300 BURN INTENSIVE CARE UNIT				0		33
00 03400 SURGICAL INTENSIVE CARE U	NIT			0		34
. 00 04000 SUBPROVIDER - IPF				0		40
. 00 04100 SUBPROVIDER - IRF				0		41
. 00 04300 NURSERY				0		43
ANCI LLARY SERVICE COST CENTERS 00 05000 OPERATI NG ROOM			0.0960	44 297, 418	28, 565	50
00 05100 RECOVERY ROOM			0.0933		3, 576	
00 05200 DELIVERY ROOM & LABOR ROO	M		0.0000		0,070	
00 05300 ANESTHESI OLOGY			0.0030		124	
00 05400 RADI OLOGY-DI AGNOSTI C			0.0590		1, 471	
01 03630 ULTRA SOUND			0. 1526	07 1, 291	197	54
00 05500 RADI OLOGY - THERAPEUTI C			0.0000	00 0	0	5!
00 05600 RADI OI SOTOPE			0.0000	00 0	0	5
00 05700 CT SCAN			0.0000		0	
. 00 05800 MRI			0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON			0.0000		0	
00 06000 LABORATORY			0.0472		2, 863	
01 06001 BLOOD LABORATORY			0.0000		0	
.00 06100 PBP CLINICAL LAB SERVICES .00 06200 WHOLE BLOOD & PACKED RED			0.0000		0	
. 00  06200 WHOLE BLOOD & PACKED RED . 00  06300 BLOOD STORING, PROCESSING			0.0000		0	
. 00 06400 I NTRAVENOUS THERAPY	a TRANS.		0.0000		0	
00 06500 RESPI RATORY THERAPY			0.0631		283	
. 00 06600 PHYSI CAL THERAPY			0. 1856		3, 362	
. 00 06700 OCCUPATI ONAL THERAPY			0.0000		0	
. 00 06800 SPEECH PATHOLOGY			0.0000		0	68
. 00 06900 ELECTROCARDI OLOGY			0.0378	82 2, 415	91	60
. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000	00 0	0	7
. 00 07100 MEDICAL SUPPLIES CHARGED			0. 0199		1, 479	
.00 07200 IMPL. DEV. CHARGED TO PAT	I ENTS		0.0770		42, 215	
00 07300 DRUGS CHARGED TO PATIENTS			0.0421		3, 929	
00 07400 RENAL DIALYSIS			0.0009		0	
00 07500 ASC (NON-DISTINCT PART) 00 07700 ALLOGENEIC HSCT ACQUISITI			0.0000		0	
OUTPATIENT SERVICE COST CENTERS			0.0000	00 0	0	' '
. 00 08800 RURAL HEALTH CLINIC			0.0000	0 00	0	88
. 00 08900 FEDERALLY QUALIFIED HEALT	H CENTER		0.0000		0	
. 00 09000 CLINIC			0.0000		0	
00 09100 EMERGENCY			0.0000		0	
00 09200 OBSERVATION BEDS (NON-DIS			0. 4428	95 0	0	92
OTHER REIMBURSABLE COST CENTERS			1	1		
00 09400 HOME PROGRAM DI ALYSI S			0.0000	00 0	0	
. 00 09500 AMBULANCE SERVICES			0.0000	~	-	95
00 09600 DURABLE MEDICAL EQUIP-REN			0.0000		0	
. 00 09700 DURABLE MEDICAL EQUIP-SOL	U		0.0000		0	
00 09850 OTHER REIMBURSABLE COSTS	rough 94 and 96 through 98)		0.0000		00 155	
	rougn 94 and 96 through 98) y Services-Program only chard	les (line 61)		1, 204, 219	88, 155	200
2.00 Net charges (line 200 min				1, 204, 219		201

1.01       DR3 amounts other than outlier payments for discharges occurring prior to 0:tober 1 (see instruction)       3, 694,248       1.0         1.02       DR3 amounts other than outlier payments for discharges occurring on or after 0:tober 1 (see instructions)       1, 584,378       1.0         1.02       DR3 for factors specific operating payment for Woold 4 BPCI for discharges occurring on or after (see instructions)       1       1.0         1.02       DR3 for factors specific operating payment for Woold 4 BPCI for discharges occurring on or after (see instructions)       2.0         2.00       Duttler payments for discharges for Moold 4 BPCI (see instructions)       2.0         2.00       Duttler payments for discharges for Moold 4 BPCI (see instructions)       2.0         3.00       Managed Care Structed Values       7.002,213         3.00       Managed Care Structed Values       0.007         5.01       TE cap adjustment for qualifing hospitals under struct or payments for the cost reporting period oxing on or before 21/23/170% (see instructions)       0.00         5.01       TE cap adjustment for qualifing hospitals under struct or payments for the cap tark to the cap t		Financial Systems LUTHERAN MUSCULOSKEL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/31/2023 9:1	pared:
Det A         LIMANT PLANS FROM CRS UNDER LPSS           10         DRX A         Amounts other than outliner payments for discharges occurring prior to Dotaber 1 (see instructions)         5, 904,246         1.0           10         DRX A         Description of the than outliner payments for discharges occurring prior to Dotaber 1 (see instructions)         1.0         Description of the than outliner payments for discharges occurring prior to Dotaber 1 (see instructions)         1.0         Description of the than outline payments for discharges occurring on or after Dotaber 1 (see instructions)         1.0         Description of the than outline payments for discharges occurring on or after Dotaber 1 (see instructions)         1.0         Description of the than outline payments for discharges occurring prior to October 1 (see instructions)         1.0         2.0           2.0         Dutliner payments for discharges occurring prior to October 1 (see instructions)         7.00,27         2.0           2.0         Dutliner payments for discharges occurring prior to Cotober 1 (see instructions)         7.00,27         2.0           2.0         Dutliner payments for discharges occurring period (see instructions)         7.00,27         2.0           2.0         Dutliner payments for discharges occurring period (see instructions)         7.00,27         2.0           2.0         Description discharges occurring period (see instructions)         7.00,27         2.0           2.0         Descrip			litle XVIII	Hospi tai	PPS	
1.00         Bic Accounts other than outline payments for discharges occurring prior to October 1 (see         0         1.00           1.00         Bic Accounts other than outline payments for discharges occurring on or after October 1 (see         1.94,484,100           1.00         Bic For Tederal specific operating payment for Model 4 BPC1 for discharges occurring on or after October 1 (see instructions)         1.0           1.00         Bic For Tederal specific operating payment for Model 4 BPC1 for discharges occurring on or after October 1 (see instructions)         1.0           0.00         Dulliter payments for discharges occurring on or after October 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after October 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after October 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after for October 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after October 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after of the october 1 (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after of (see instructions)         2.0           0.00         Dulliter payments for discharges occurring on or after of (see instructions)					1.00	
1.01       DBG amounts other than outlier payments for discharges occurring on or after October 1 (see       3, 900, 248       1.0         1.02       DGG amounts of the noutlier payments for discharges occurring on or after October 1 (see       1, 554,376       1.0         1.02       DGG amounts of the operating payment for Wold 4 BPC1 for discharges occurring on or after       0       1.0         1.03       DGG for forderd specific operating payment for Wold 4 BPC1 for discharges occurring on or after       0       0         1.04       DEG for forderd specific operating payment for Wold 4 BPC1 for discharges occurring on or after       0       0         2.00       Outlier payments for discharges occurring on or after October 1 (see instructions)       2.0       0         2.00       Outlier payments for discharges occurring on or after October 1 (see instructions)       0       0         3.00       Managed Caru Structure and operating not after October 1 (see instructions)       0       0       0         3.00       Managed Caru Structure and operating not after October 1 (see instructions)       0	1.00				0	1.00
1.02       BRG amounts other than outline payment for Wedel 4 BRCI for discharges accurring prior to October       1.554.376         1.03       URE for federal specific operating payment for Model 4 BRCI for discharges accurring on or after October       1.00         1.04       URE for federal specific operating payment for Model 4 BRCI for discharges courring on or after October       1.00         1.04       URE for reduced a scharges. (see instructions)       2.00         0.01       Uniter reduced into amount       0.00         0.01       Uniter reduced into amount on the damage scharges. (see instructions)       1.00         0.02       Uniter reduced into amount on the logs in the cost reporting period (see instructions)       3.42         0.01       URE damage scharges. (see instructions)       0.00       5.00         0.01       TE count for all operiting amount on the Higgs and a log the damage scharges for the cost reporting period (see instructions)       0.00       5.00         0.01       TE count for all operiting cam comparison for the cost reporting period (see instructions)       0.00       5.00         0.02       TE count for all operiting cam comparison for the cost reporting period (see instructions) </td <td>1.01</td> <td>DRG amounts other than outlier payments for discharges occurri</td> <td>ng prior to October 1 (</td> <td>see</td> <td>3, 904, 248</td> <td>1.01</td>	1.01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (	see	3, 904, 248	1.01
1.03       DRC for foderal specific operating payment for Model 4 BPCI for discharges occurring prior to 0-cloper 1       0       0.10         1.04       DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after       1.0         1.04       DRC for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after       1.0         2.05       Duttier payment for discharges for Model 4 BPCI (see instructions)       2.0         2.01       Duttier payment for discharges occurring prior to 0-cloper 1 (see instructions)       7.100.221         2.03       Duttier payment for discharges occurring prior to 0-cloper 1 (see instructions)       7.100.221         2.03       Duttier payment for discharges occurring prior to 0-cloper 1 (see instructions)       7.100.221         3.00       Mongaet Care Shual ated Nameter of days in the cost reporting period ending on new programs in accordance with 42 LPR 413.79(c)       0.00       5.0         5.00       TE count for allopathic and ostepathic programs that meet the criteria for an addion to the cap for 0.00       0.00       6.00         6.00       TE count for allopathic and ostepathic programs specified under 42 CPR 412 105(7(1)(1)(0)(0)(1)       0.00       7.0         7.01       Care programs in accordance with 42 LPR 41.105(7(1)(1)(0)(0)(1)       0.00       7.0         7.02       Care programs in accordance with 42 CPR 412 105(7(1)(1)(0)(0)(1)	1.02	DRG amounts other than outlier payments for discharges occurring	ng on or after October	1 (see	1, 554, 376	1. 02
1.04       DBC for federal specific coperating payment for Woold 4 BPCI for discharges occurring on or after (see instructions)       0       0         2.00       Duttler payments for discharges (see instructions)       0       0         2.00       Duttler payments for discharges or Woold 4 BPCI (see instructions)       0       0         2.00       Duttler payments for discharges or Woold 4 BPCI (see instructions)       0       0         2.00       Duttler payments for discharges or Woold 4 BPCI (see instructions)       0       0         2.00       Duttler payments for discharges or Woold 4 BPCI (see instructions)       0       0         3.00       Bad days moliable ad divide by matter of days in the cost reporting period (see instructions)       0.00       3.4       4.00         5.00       Fit count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 123/1796, cae instructions)       0.00       5.00         5.01       Fit count for all opathic and osteopathic programs for the most recent cost discharges (b) (b) (b) (b) (c) (b) (c) (b) (c) (b) (c) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	1.03	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	prior to October	0	1. 03
2.01       Outlier reconciliation amount       0       0.02       0.011er payments for discharges or Wold 4 BPCI (see instructions)       0.02       0.010         0.03       Outlier payments for discharges occurring prior to October 1 (see instructions)       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.010       0.000 <t< td=""><td>1.04</td><td>DRG for federal specific operating payment for Model 4 BPCI for</td><td>r discharges occurring</td><td>on or after</td><td>0</td><td>1. 04</td></t<>	1.04	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	on or after	0	1. 04
2.03       Outlier powents for dischargue occurring on raite October 1 (see instructions)       17.557       2.0.         2.04       Outlier powents for dischargue occurring on raiter October 1 (see instructions)       7.802.221       3.00         3.00       Nanaged Care Simulated Payments       7.802.221       3.00         3.01       The cash inducted by under of days in the cost reporting period (see instructions)       3.23       4.00         5.00       The cash inducted Payments       0.00       5.00       5.00       5.00         5.01       The cash inducted Payments       0.00       5.00       6.00       6.00       6.00         5.01       The cash inducted Payments       0.00       5.00       6.00       7.00       MAS Section 422 reduction anount to the ME cap is specified under 42 CRE \$412.005(7)(1)(1)(10)(10)(10)(10)(10)(10)(10)(10)(					0	2.00 2.01
2.04       Outlier poyments for dischargies occurring on or after October 1 (see instructions)       0.2.0.         3.04       Dead days available divided by number of days in the cost reporting period (see instructions)       34.28         3.00       File count for all opathic and osteppathic programs for the most recent cost reporting period ending on one period ending on the period ending on the cost opagrams in accordance with 42.274 (24.21)       0.00       5.00         5.00       File count for all opathic and osteppathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42.274 (24.21)       0.00       6.00         6.00       File count for all opathic in the the MC cap as specified under 42.078 (42.105(f)(1)(1v)(8)(2)       0.00       7.0         7.00       MAA § 5503 resultion to the MC cap as specified under 42.078 (42.105(f)(1)(1v)(8)(2)       0.00       7.0         7.01       MAA § 5503 resultion to the MC cap as specified under 42.078 (42.105(f)(1)(1v)(8)(2)       0.00       7.0         7.02       Adjustment (increase or decrease) to the hospital's rural track programs free conduce with 43.75(b)       0.00       7.0         7.03       Adjustment (increase or decrease) to the HE coap allost under 5 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions       0.00       8.0         8.01       Maint of increase if the hospital was awarded FTE cap slots under 5 503 of the ACA. If the cost in analosthic programs in accordance with 43.7.01, was an allos					-	2.02
3.00       Managed Care Simulated Paymetrs       7.802.221       3.00         3.00       Managed Care Simulated Paymetrs       3.42       4.00         1.00       Red days swall tails of uside by number of days in the cost reporting period (see instructions)       3.42       4.0         0.01       FIE count for all opatibility and extemptify programs for the most recent cost reporting period ending on 0.00       5.0         0.01       FIE count for all opatibility and the cap step tails of the CAA 2021 (see instructions)       0.00       6.0         0.01       FIE count for all opatibility and the cap step tails under \$131 of the CAA 2021 (see instructions)       0.00       6.0         0.01       FIE count for all opatibility and and step tails under \$131 of the CAA 2021 (see instructions)       0.00       6.0         0.02       Rural Frack programs in accordance with 42 CFR 413.75(0)       0.00       7.0       0.00       7.0         0.03       Statistic stati						2.03
Indirect Medical Education Adjustment         Indirect Medical Education Adjustment           0.00         File count For allopathic and ostcopathic programs for the most recent cost reporting period ending on or before 12/3/1996 (see instructions)         0.00         5.0           0.01         File count for allopathic and ostcopathic programs that meet the criteria for an add-on to the cap for 0.00         6.00           0.02         File count for allopathic and ostcopathic programs that meet the criteria for an add-on to the cap for 0.00         6.00           0.02         Bardi Track program FE cap limit attion adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)         0.00         7.00           0.04         Asotin 422 refueltion amount to the IME cap as specified under 42 GER \$412.105(Cf)(1)(V)(9)(2) If the 0.00         7.00           7.02         Adjustment (increase or decrease) to the hospital's furnal track program FTE limitations() for runal track programs for 0.00         7.00           8.00         Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00         8.00           8.00         The ground of increase if the hospital was awarded FTE cap slots under \$5503 of the CAA. If the cost 0.00         8.00           9.00         The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions)         0.00         8.00           8.01         The amount of increase if the hospital was awa					-	3.00
5.00       FTE count for allopathic and distempathic programs for the most recent cost reporting period ending on or before 12/31/976 (see instructions)       0.00       5.00         5.01       FTE cap adjustment for qualifing hespitals under \$131 of the CAA 2021 (see instructions)       0.00       5.00         5.01       FTE cap adjustment for qualifing hespitals under \$131 of the CAA 2021 (see instructions)       0.00       5.00         6.02       Rue in the cap the cap the comparison that neet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 412 (DS(T)(1)(v)(B)(1)       0.00       6.00       7.00         0.04       RADS extradios July 1, 2011 then see instructions.       0.00       7.00       0.00       7.00         0.04       RADS extradios July 1, 2011 then see instructions.       0.00       7.00       0.00       7.00         0.04       RADS extradios July 1, 2011 then see instructions.       0.00       0.00       8.00         0.05       RADS (May May 10, 2022)       See instructions.       0.00       8.00         0.05       RADS (May May 10, 2022)       See instructions.       0.00       8.00         0.06       RADS (May May 10, 2023)       See instructions.       0.00       8.00         0.07       FR 40057 (May May 10, 2023)       See instructions.       0.00       8.00         0.08	4.00		ting period (see instru	ictions)	34.28	4.00
6.00       FTE count for allopathic and osteopathic programs that meet the criteria for an addion to the cap for new programs. In accordance with 42 CFR 413.79(e)       0.00       6.00         6.26       Rural track program FTE cap limitation and ustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)       0.00       6.00         7.00       MAA Saction and the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(6)(2) if the 0.00       7.00         7.01       MAA Saction and the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(6)(2) if the 0.00       7.00         7.02       Adjustment (increase or decrease) to the HE cons odd the odd trade programs in accordance with 413.75(b) and 67 FR 4005(August 10, 2022) (see instructions)       0.00       7.00         8.00       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for artific in Loope (August 1, 2002).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions).       0.00       8.00         8.02       The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see instructions).       0.00       8.00         8.02       The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see inst	5.00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5.00
6.26       Rural track program FEE cap limitation adjustment after the cap-building window closed under \$127 of the CA 201 (see instructions)       0.00       6.2         7.00       MAA Section 422 reduction amount to the IME cap as specified under 42 CR \$412.105(f)(1)(iv)(8)(1)       0.00       7.00         7.01       MAA Section 422 reduction amount to the IME cap as specified under 42 CR \$412.105(f)(1)(iv)(8)(1)       0.00       7.00         7.02       Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 413.75(b) and 87 R4007 (August 10. 2022) (see instructions)       0.00       8.00         8.00       Adjustment (increase or decrease) to the TE count for al topathic and osteopathic programs for report straddles July 1. 2011, see instructions)       0.00       8.00         8.01       The anount of increase if the hospital was awarded FE cap slots under \$126 of the CAA 2021 (see instructions)       0.00       8.0         8.21       The anount of increase if the hospital was awarded FE cap slots under \$26 of the CAA 2021 (see instructions)       0.00       8.0         8.22       The anount of increase if the hospital was awarded FE cap slots under \$26 of the CAA 2021 (see instructions)       0.00       8.0         8.23       The anount of increase is not can anot sepathic programs.       0.00       8.0         8.24       The anount of increase is the cap slots inder \$25 do the CAA 2021 (see instructions)       0.00       0.00      <						5. 01 6. 00
7.00       MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(7)(1)(V)(8)(2) If the 0.00       7.00         7.01       MCA §5503 reduction amount to the IME cap as specified under 42 CFR §412.105(7)(1)(V)(8)(2) If the 0.00       7.00         7.01       MCA §5503 reduction amount to the IME cap as specified under 42 CFR §412.105(7)(1)(V)(8)(2) If the 0.00       7.00         7.02       Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 43.75(b) and 87 FR 4005 (August 10, 2022) (see Instructions)       0.00       8.00         8.00       Adjustment (increase or decrease) to the FTE count for al logathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b) (1)(V). 44 FR 20340 (Msy 12, 10, 10, 10, 11, 13, 19(c)(2)(V)). 44 FR 20340 (Msy 12, 10, 10, 11, 11, 11, 11, 11, 11, 11, 12, 11, 11	6. 26	Rural track program FTE cap limitation adjustment after the ca	p-building window close	d under §127 of	0.00	6. 26
7.01       ACA § 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the cost cost report straidles July 1, 2011 then see instructions.       0.00       7.0         7.02       Adjustment (increase or decrease) to the hospital's rural track programs ITI limitation(S) for rural track for Medicane G&E affiliated programs in accordance with 413.75(b) and 67 FR 4005 (August 10, 2022) (see instructions)       0.00       8.00         8.0       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 40060 (August 1, 2002).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report istraddle suly 1, 2011, see instructions.       0.00       8.00         8.11       The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions)       0.00       8.00         8.21       The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions)       0.00       8.00         9.02       Sun of lines 5.01, plus line 6, plus lines 8.01 through 8.27 (see instructions)       0.00       10.00         10.00       FE count for residents in dental and podiatric programs.       0.00       10.00       10.00         10.00       The amount of increase if the penultimate year if that year ended on or after September	7 00		nder 42 CFR 8412 105(f)	$(1)(i_{V})(B)(1)$	0.00	7.00
7.02       Adjustment (increase or decrease) to the hospital's rural track programs FII initiation(s) for rural track for Medicare (ME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)       7.02         8.04       Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiliated programs in accordance with 413.75(b), 413.75(c) (2)(i), 64 FR 26340 (Mey 12, 1998), and 67 FR 50069 (August 1, 2002).       0.00       8.0         8.04       Adjustment (increase) to the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.0         8.02       The amount of increase If the hospital was awarded FTE cap slots under § 5126 of the CAA 2021 (see instructions)       0.00       8.0         8.10       Through III ne 6 Juli IIII ne 6 Juli III  ne 6 Juli III  ne 6 Juli III ne 6 Juli IIII ne 6 Juli IIII ne 6 Juli III ne 6 Juli IIII ne 6 Juli IIII ne 6 Juli IIII ne 6 Juli IIIIII ne 6 Juli IIII ne 6 Juli IIIII ne 6 Juli IIII ne 6		ACA § 5503 reduction amount to the IME cap as specified under				7.01
9.00       Adjustment (Increase or decrease) to the FTE count for allopathic and ostepathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5505 of ACA. (see instructions).       0.00       8.0         8.02       The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions).       0.00       8.0         8.11       The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 0.00       8.2         9.00       Sum of lines 5 and 5.01, plus lines 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.20 through 8.27 (see instructions)       0.00       10.00         10.00       FTE count for residents in dental and podiatric programs.       0.00       10.00       10.00         12.00       Current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       10.00       15.00         13.00       Adjustment for residents in initial years of the program (see instructions)       0.00       16.00       0.000       16.00         14.00       Total allowable FTE count for the penultimate year of the program (see instructions)       0.000       16.00	7.02	Adjustment (increase or decrease) to the hospital's rural track track programs with a rural track for Medicare GME affiliated			0.00	7. 02
8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.0         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)       0.00       8.0         8.21       The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)       0.00       8.0         8.21       The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)       0.00       8.0         9.00       Sum of lines 5 and 5.01, plus line 8, olus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)       0.00       10.00         10.00       FTE count for reledent in dental and polatric programs.       0.00       10.00       11.00         12.00       Current year reledent to the penultimate year if that year ended on or after September 30, 1997, 0.00       14.00         13.00       Total allowable FTE count for the penultimate year if the year ended on or after September 30, 1997, 0.00       15.00         14.00       Total allowable grader by program or hospital closure       0.00       16.00         15.00       Sum of lines 2 and 2 blaced by program or hospital closure       0.00       16.00         16.00 <t< td=""><td>8.00</td><td>Adjustment (increase or decrease) to the FTE count for allopatl affiliated programs in accordance with 42 CFR 413.75(b), 413.7</td><td></td><td></td><td>0.00</td><td>8.00</td></t<>	8.00	Adjustment (increase or decrease) to the FTE count for allopatl affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0.00	8.00
8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital       0.00       8.0         9.01       Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)       0.00       9.00         9.00       Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line do steopathic programs in the current year from your records       0.00       10.00         10.00       FTE count for residents in dental and podiatric programs.       0.00       10.00       11.00         2.00       Current year allowable FTE count for the prior year.       0.00       1.00         11.00       Contervise enter zero.       0.00       1.00         12.00       Current year allowable FTE count       0.00       1.00         13.00       Adjustent for residents displaced by program or hospital closure       0.00       16.00         13.00       Current year allowable FTE count       0.00       16.00       17.00         14.01       Vide antio (line 18 divided by line 4).       0.000       18.00         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000       17.00         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0	8.01	The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the	ACA. If the cost	0.00	8. 01
8.21       The amount of Increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)       0.00       8.2         9.00       Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)       0.00       9.00         10.00       FTE count for residents in dental and podiatric programs in the current year from your records       0.00       10.00         12.00       Current year allowable FTE count for the prior year.       0.00       12.00         13.00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       15.00         16.00       Adjustment for residents in initial years of the program (see instructions)       0.00       16.00         17.00       Erfer count for residents displaced by program or hospital closure       0.00       18.00         18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Errer the lesser of lines 19 or 20 (see instructions)       0.000       18.00         19.00       Enter the lesser of lines 19 or 20 (see instructions)       0.22.00       22.00         10.00       Enter the lesser of lines 19 or 20 (see instructions)       0.22.00       22.00         10.01       Expayment adjustment - Manage	8.02	The amount of increase if the hospital was awarded FTE cap slo	ts from a closed teachi	ng hospi tal	0.00	8. 02
9.00Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, 01 through 6.27 (see instructions)0.009.0010.00FTE count for allopathic and osteopathic programs in the current year from your records0.0010.0011.00FTE count for residents in dental and podiatric programs.0.0010.0012.00Current year allowable FTE count for the prior year.0.0012.0013.00Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.0.0013.0015.00Sum of lines 12 through 14 divided by 3.0.0015.0016.00Adjustment for residents in initial years of the program (see instructions)0.0016.0017.00Current year alignation to bed ratio (see instructions)0.0018.0019.00Current year resident to bed ratio (see instructions)0.00000019.0010.00Enter the lesser of lines 19 or 20 (see instructions)0.00000021.0010.01IME payment adjustment - Managed Care (see instructions)0.00000021.0010.01IME payment adjustment for the Add-on for § 422 of the MMA0.00000024.0023.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see lines adjustment factor. (see instructions)0.00000026.0024.00IME payment adjustment factor. (see instructions)0.28.0028.0026.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (se	8. 21	The amount of increase if the hospital was awarded FTE cap slo	ts under §126 of the CA	A 2021 (see	0.00	8. 21
10:00       FTE count for allopathic and osteopathic programs in the current year from your records       0.00       10.00         11:00       FTE count for residents in dental and podiatric programs.       0.00       10.00         12:00       Current year allowable FTE count for the prior year.       0.00       10.00         13:00       Total allowable FTE count for the prior year.       0.00       13.00         14:00       Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       13.00         15:00       Sum of lines 12 through 14 divided by 3.       0.00       16.00         16:00       Adjustment for residents displaced by program or hospital closure       0.00       16.00         16:00       Gurrent year resident to bed ratio (see instructions)       0.00       17.00         10:00       Current year resident to bed ratio (see instructions)       0.000000       0.00         10:00       Prior year resident to bed ratio (see instructions)       0.000000       0.00         10:01       IME payment adjustment (see instructions)       0.000000       0.00         10:02       IME payment adjustment for the Add-on for § 422 of the MMA       0.000000       0.00         10:01       IME payment adjustment for the 25 by line 4)       0.000000       0.00	9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through		1 7.01, plus or	0.00	9.00
12:00       Current year allowable FTE (see instructions)       0.00       12.00         13:00       Total allowable FTE count for the prior year.       0.00       13.00         14:00       Total allowable FTE count for the penultinate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       14.00         15:00       Sum of lines 12 through 14 divided by 3.       0.00       15.00         16:00       Adjustment for residents in initial years of the program (see instructions)       0.00       16.00         17:00       Adjusted rolling average FTE count       0.00       16.00       0.00         18:00       Adjusted rolling average FTE count       0.00       18.00         19:00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       12.00         10:00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       20.00         10:01       Me payment adjustment for the Addoon for § 422 of the MMA       0.000000       22.00         10:02       IME payment adjustment for the Addoon for § 422 of the MMA       0.000000       23.00         10:01       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         10:16       If the adoon adjustment amount (see instructions)       0.000000<		FTE count for allopathic and osteopathic programs in the current	. ,	ds		
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33.00Allowable disproportionate share percentage (see instructions)0.0033.00		Percentage of Medicaid patient days (see instructions)				31.00
		Disproportionate share adjustment (see instructions)				33.00

CALCULATION OF REIMBURSEMENT SETTLEMENT         Provider CON: 15-0168         Provider CON: 15	Heal th	Financial Systems LUTHERAN MUSCULOSKE	LETAL CENTER	In Lie	u of Form CMS-2	2552-10
Title XVIII         Inspiral         PPS           Incompensated Care Expendence Care Expendence         Prior to 107         Prior to 107         Prior to 107           Sto         Table Uncompensated Care Expendence         Sto         Table Uncompensated Care Expendence         Sto         Sto         Sto         Sto         Table Uncompensated Care Expendence         Sto         S				Period: From 01/01/2022	Worksheet E Part A Date/Time Pre	pared:
Prior to 107 DerAfter 1071           1.00         2.00           30.00         Total uncompensated care amount (see instructions)         0         2.00           30.00         Febora 3 (EP, Instructions)         0         0.00000000         35.00           30.00         Febora 3 (EP, Instructions)         0         0.00000000         35.00           30.00         Feorata share of the hospital UCP, Including supplemental UCP (see Instructions)         0         0         35.00           40.00         Total Medicare discharges (cee Instructions)         0         0         35.00         0         0.00000000         36.00           40.01         Total Medicare discharges (cee Instructions)         0         0         36.00         0         36.00         0         36.00         0         36.00         0         36.00         0         36.00         0         36.00         0         36.00         0         36.00         36.00         0         36.00         36.00         0         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00         36.00				Hospi tal		3 811
Incompensated Care Payment Adjustment         1.00         2.00           35:00         Total uncompensated care amount (see instructions)         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.00000000         0.00000000         35:0         0.0000000         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         35:0         0.00000000         0.000000000         45:0         0.00000000000000000000000000000000000			II the AVIII			
Incompensated Care Payment Adjustment         Incompensate Care Payment Adjustment         IncomPayment Payment Payme						
35 of Pactor 3 (see instructions)       0.00000000       0.00000000       0.00000000         35 02 (Hospital UCP, including supplemental UCP (if line 34 is zero, enter zero on this line)       0       0       0         36 00 (rate share of the hospital UCP, including supplemental UCP (if line 34 is zero, enter zero on this line)       0 <td< td=""><td></td><td>Uncompensated Care Payment Adjustment</td><td></td><td></td><td></td><td></td></td<>		Uncompensated Care Payment Adjustment				
35 02       Hospital UCP, including supplemental UCP (if line 34 is zero, enter zero on this line)       0       0       35 03         35 03       Pro rata share of the hospital UCP, including supplemental UCP (see instructions)       0       0       36 03         400       Total symmeth for high percentage of FSR0 beneficiary discharges (times 40 through 49)       0       36 0         4100       Total ESR0 Medicare instructions)       0       40 0         4200       For and sharges (see Instructions)       0       40 0         4200       Total ESR0 Medicare covered and paid discharges (see Instructions)       0       43 0         43 00       Total Hedicare fSR0 inpatient days (see instructions)       0       43 0         45 00       Verage weekly cost for dialysis treatments (see instructions)       0       44 0         46 00       Total additional payment (line 45 times line 44 times line 41.01)       0       0       46 0         47 00       Total additional payment for inpatient operating costs (see instructions)       5, 476, 181       47.0         48 00       Total additional payment for inpatient operating costs (see instructions)       0       55.0         50.00       Payment for inpatient operating costs (see instructions)       0       55.0         51.00       Exectin payment for inpatient operating costs (rom Wk	35.00	Total uncompensated care amount (see instructions)		0	0	35.00
(see instructions)       (see inst	35.01	Factor 3 (see instructions)		0. 00000000	0.00000000	35.01
35. 02       Pro rata share of the hospital UCP, including supplemental UCP (see instructions)       0	35.02		enter zero on this line)	0	0	35.02
36.00       Total UCP adjustment (sum of columes 1 and 2 on line 35.03)       0       36.0         40.00       Total Medicare discharges (see instructions)       0       40.0         40.00       Total Medicare discharges (see instructions)       0       41.0         41.00       Total ESRD Medicare covered and paid discharges (see instructions)       0       41.0         42.00       Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00       42.0         43.00       Total Medicare ESRD Inpatient days (see instructions)       0       43.0         44.00       Ratio of average length of stays to one week (line 43 times line 41.01)       0       0       46.0         45.00       Neurage weekly cost for dialysis treatments (see instructions)       0.00       46.0       46.0         46.00       Total additional payment (line 45 times line 44 times line 41.01)       0       64.0       47.0         47.00       Total payment for inpatient program capital (from Wkst. L, Pt. I. 11, see instructions)       5.476.11 49.0       42.0         50.00       Payment for inpatient program capital (Wst. L, Pt. II. see instructions)       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 49.0       5.476.61 4	25 02				0	25 02
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)       0         40.00 Total ESRD Medicare discharges (see instructions)       0         41.00 Total ESRD Medicare discharges (see instructions)       0         41.01 Total ESRD Medicare discharges (see instructions)       0         42.00 Divide line 41 by line 40 (lf less than 10%, you do not qualify for adjustment)       0.00         42.00 Total ESRD Medicare discharges (see instructions)       0         43.00 Total Medicare ESRD Medicare discharges (see instructions)       0         43.00 Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000         44.00 Nortal additional payment (line 45 tines line 41.01)       5,476.101         45.00 Average weekly cost for dialysis treatments (see instructions)       0.00         45.00 Average meekly cost for dialysis treatments (see instructions)       5,476.101         45.00 Total payment for inpatient operating costs (see instructions)       5,476.101         45.00 Total payment for inpatient operating costs (see instructions)       1.00         45.00 Total payment for inpatient program capital (from Wkst. L +t. line 49 see instructions).       421.678         55.00 Direct graduate medical education payment (from Wkst. L +4. line 49 see instructions).       53.67         56.00 Average acquisition cost (kset instructions)       53.67         57.00 Average			P (see instructions)	0	0	
40.00       Total Medicare discharges (see instructions)       0       40.0         10.00       Total ESR0 Modicare covered and paid discharges (see instructions)       0       0         11.00       Total ESR0 Modicare covered and paid discharges (see instructions)       0       0         12.00       Divide line 41 by line 40 (line 18 divided by line 11 divided by 7       0.00000       43.0         13.00       Average weekly cost for dialysis treatments (see instructions)       0.00       0         14.00       Total additional payment (line 45 times line 44 limes line 41.01)       0       0         14.00       Ratio of average length of startuctions)       0.00       44.0         14.00       Ratio of average length of startuctions)       0.00       45.0         14.00       Ratio of average length of startuctions)       0.00       44.0         14.00       Itos instructions)       0.00       44.0         14.00       Itos instructions)       0.00       45.16.16.16.16.16.16.16.16.16.16.16.16.16.	30.00		scharges (lines 40 throug	-		30.00
41.00       Total ESR0 Medicare discharges (see instructions)       0       41.0         41.01       Total ESR0 Medicare discharges (see instructions)       0       42.0         41.01       Total ESR0 Medicare covered and paid discharges (see instructions)       0       42.0         42.00       Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00       43.0         43.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.0         45.00       Average weekly cost for dialysis treatments (see instructions)       0       0       45.0         45.00       Average weekly cost for dialysis treatments (see instructions)       5,476,181       47.0         47.00       Subtotal (see instructions)       0       48.0         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals       0       47.6         49.00       Total payment for inpatient operating costs (see instructions)       5,476,181       42.1,678       50.0         50.00       Payment for inpatient program capital (from West L. Pt. 11, see instructions)       5       51.0       51.0       51.0       52.00       10.14 Healt Medicare Estimation (See Instructions)       5       51.0       51.0       52.00       52.00       52.00 <td< td=""><td>40.00</td><td></td><td></td><td></td><td></td><td>40.00</td></td<>	40.00					40.00
41.0       Total ESRD Medicare covered and jaid discharges (see instructions)       0       41.0         42.00       Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)       0.00       43.0         43.00       Total Medicare ESRD inpatient days (see instructions)       0.00       43.0         43.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000       44.0         43.00       Ratio of average weekly cost for dialysis treatments (see instructions)       0.00       45.0         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.0         45.00       Horspect (see instructions)       0.00       45.0         47.00       Itime 45 times line 44 times line 41.01       47.0       47.0         47.00       Horspect (see instructions)       5.476.181       47.0         47.00       Total payment for inpatient operating costs (see instructions)       5.476.181       47.0         47.00       Total payment for inpatient program capital (from West, L, Pt. 111, see Instructions)       5.10       51.0         50.00       Preyment for inpatient program capital (from West, L, Pt. 111, see instructions)       5.10       52.0         51.00       Exception payment for maxima (from West, L, Pt. 111, see instructions)       5.10		5				41.00
42.00       Divide Line 41 by Line 40 (if Less than 10%, you do not qualify for adjustment)       0.00       42.2         43.00       Total Medicare ESR0 inpatient days (see instructions)       0.000       43.2         43.00       Average weekly cost for dialysis treatments (see instructions)       0.000       43.2         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.0         46.00       Total additional payment (ine 45 times line 44 times line 41.01)       0       64.0         47.01       5.476.181       47.0       47.0         48.00       Total payment for inpatient operating costs (see instructions)       5.476.181       47.0         49.00       Total payment for inpatient program capital (Wkst. L, Pt. Lin AP Pt. Lin, see instructions)       5.476.181       42.0         51.00       Exception payment for inpatient program capital (Wkst. L, Pt. Lin 49 see instructions)       5.1       52.0         52.00       Direct graduate medical education payment (from Wkst. E-4, Line 49 see instructions)       55.0       51.0         53.00       Not organ acquisition costs (Wkst. D-4 Pt. III, colum 9, Lines 30 through 35).       55.0       55.0         54.00       Special add-on payments for mew technologies       5.4.0       55.0       55.0       55.0       55.0       55.0       55.0 <td< td=""><td></td><td></td><td>i ons)</td><td></td><td></td><td>41.01</td></td<>			i ons)			41.01
43.00       Total Medicare ESRD inpatient days (see instructions)       0       43.0         44.00       Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7       0.000000         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       44.0         85.00       Average weekly cost for dialysis treatments (see instructions)       0.00       44.0         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       44.0         45.00       Horage weekly cost for dialysis treatments (see instructions)       5,476.181       47.0         45.00       Horage weekly cost for dialysis treatments (see instructions)       5,476.181       47.0         45.00       Horage methy cost for dialysis treatments (see instructions)       5,476.181       47.0         47.00       Total payment for inpatient operating costs (see instructions)       5,476.181       47.0         50.00       Payment for inpatient program capital (from Wkst. L, Pt. III, see instructions)       51.0       51.0         51.00       Exception payment file Managed Care payment       63.2       54.0       54.0       54.0         55.00       Norsing and Allied Healt Managed Care payment       63.5       65.0       65.0       65.0       65.0       65.0       65.0       65.0 <td>42.00</td> <td></td> <td></td> <td>0.00</td> <td></td> <td>42.00</td>	42.00			0.00		42.00
days)       0.00       45.0         45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.0         46.00       Total additional payment (line 45 times line 44 times line 41.01)       0       45.0         47.00       Subtotal (see instructions)       5.476.181       47.0         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals       5.476.181       40.0         49.00       Total payment for inpatient operating costs (see instructions)       5.476.181       40.0         50.00       Payment for inpatient program capital (from Wkst. L. Pt. 1 and Pt. III, see instructions).       6.421.678       50.0         51.00       Exception payment for inpatient program capital (Wkst. L. Pt. III, see instructions).       0.52.0       5.476.181       40.0         52.00       Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).       0.52.0       5.10.0         52.00       Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)       5.476.181       40.0         55.00       Cost of physicians' services in a teaching hospital (see intructions)       0.55.0       5.60.0         56.00       Cost of physicians' services in a teaching hospital (see intructions)       0.50.0       5.67.0         60.00       Cost of physicians' services in a teach	43.00		5 5 /	0		43.00
45.00       Average weekly cost for dialysis treatments (see instructions)       0.00       45.0         40.00       Total additional payment (ine 45 times line 44 times line 41.01)       0       45.00         48.00       Subtotal (see instructions)       5.476.181       47.00         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals on line (from West, L, Pt. L and Pt. II, as applicable)       5.476.181       47.00         49.00       Total payment for inpatient program capital (Wrst, L, Pt. L and Pt. II, see instructions)       421.678       50.0         51.00       Exception payment for inpatient program capital (Wrst, L, Pt. L line 49 see instructions).       0.52.0       5.476.181       40.53.0         52.00       Direct graduate medical education payment (from Wkst, L, Pt. L line 69)       5.476.181       50.54.0         55.01       Cellular therapy acquisition cost (see instructions)       0.54.0       55.0       55.00         56.00       Cost of physiclans' services in a teaching hospital (see intructions)       0.55.0       56.00       56.00       57.00       58.00       55.07       61.01       57.07       60.01       57.07       59.00       55.07       61.01       57.07       60.02       57.00       56.00       56.00       57.07       60.02       57.07       60.02       57.07	44.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.00
44.6.00       Total additional payment (line 45 times line 44 times line 41.01)       0       64.6.0         47.00       Subtotal (see instructions)       5,476,181         48.00       Interval to the payment for inpatient operating costs (see instructions)       10.00         49.00       Total addition payment for inpatient operating costs (see instructions)       5,476,181         40.00       Total add-on payment for inpatient program capital (Wkst. L, Pt. 111, see instructions).       0         51.00       Exception payment for inpatient program capital (Wkst. L, Pt. 111, see instructions).       0         52.00       Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).       0         52.00       Direct graduate medical education payment (from Wkst. E-4, line 69)       5.476,181         53.00       Varing and Allied Nearby Agage is intructions)       0       5.4         54.01       Ister isolation cost (see instructions)       0       5.4         55.00       Cost of physicians' services in a teaching hospital (see intructions)       0       5.5         56.00       Cost of physicians' services instructions)       0       5.6         57.00       Additure service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)       0       5.8         60.00       Primary payer payments       0       5.6 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
47.00       Subtotal (see instructions)       5,476,181       47.0         48.00       Hospital specific payments (to be completed by SCH and MDH, small rural hospitals of only. (see instructions)       1.00         49.00       Total payment for inpatient operating costs (see instructions)       5,476,181       48.0         49.00       Total payment for inpatient program capital (from Wkst. L, Pt. 1 and Pt. II, as applicable)       5,476,181       42.1,678       50.0         51.00       Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions).       0       51.0       62.2       51.0       51.0       52.0       51.0       52.0       51.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       52.0       53.0       64.0       56.0       55.0			-	0.00		45.00
48.0       hospital specific payments (to be completed by SCH and MDH, small rural hospitals       0       48.0         49.00       Total payment for inpatient operating costs (see instructions)       1.00       1.00         50.00       Payment for inpatient program capital (from Wkst L, Pt I and Pt, II, as applicable)       421,678       50.00         51.00       Exception payment for inpatient program capital (Krom Wkst L, Pt I and Pt, II, see instructions)       0.51.0       52.0         53.00       Nursing and Allied Healt Managed Care payment       6.51.0       52.0         54.01       Special add-on payments for new technologies       0.54.0         55.01       Cellular therapy acquisition cost (Wkst L -4 Pt, III, col. 1, line 69)       0.55.0         56.00       Cost of physicians' services in a teaching hospital (see intructions)       0.55.0         57.00       Routine service other pass through costs (from Wkst D, Pt. III, col. 11 line 200)       0.58.0         58.00       Ancillary service other pass through costs (from Wkst D, Pt. IV, col. 11 line 200)       0.58.0         59.00       Total (sum of amounts on lines 49 through 58)       0.65.0         60.00       Crimary payer payments       5.897,859         61.00       Total amount payable for program beneficiaries (line 59 minus line 60)       5.897,859         62.00       Deductible so billed to progra			. 01)	0		46.00
only. (see instructions)         Amount           49.00         Total payment for inpatient operating costs (see instructions)         5.476,181.492           50.00         Payment for inpatient program capital (from Wkst. L, Pt. 11, see instructions)         421,678           51.00         Exception payment for inpatient program capital (Wkst. L, Pt. 111, see instructions)         6.576,181.492           52.00         Direct graduate medical education payment (from Wkst. L, Pt. 111, see instructions)         6.51.0           52.00         Nursing and Allied Health Managed Care payment         6.53.0           53.00         Nursing ind Allied Health Managed Care payment         6.54.0           55.00         Net organ acquisition cost (see instructions)         6.54.0           50.00         For gran acquisition cost (see instructions)         6.55.0           50.00         Cost of physicians' service other pass through costs (from Wkst. D, Pt. 111, column 9, lines 30 through 35).         6.57.0           50.00         Total amount son lines 49 through 58)         6.60.0         6.60.0           60.00         Primary payer payments         5.897,859         6.62.0           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         5.897,859         6.62.0           62.00         Deductibles billed to program beneficiaries (see instructions)         5.678 <td></td> <td></td> <td></td> <td></td> <td></td> <td>47.00</td>						47.00
Amount         0.00           49.00         Total payment for inpatient operating costs (see instructions)         1.00           50.00         Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)         421,678           51.00         Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)         0.81           52.00         Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).         0.52.0           53.00         Nursing and Allield Heal th Managed Care payment         0.53.0           54.01         Islet isolation add-on payments         0.54.0           55.01         Cellular therapy acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0.55.0           56.00         Cost of physicians' services in a teaching hospital (see intructions)         0.55.0           57.00         Rutine service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)         0.57.0           58.00         Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)         5.897.859           50.00         Cotal anount payable for program beneficiaries (line 59 minus line 60)         5.897.859           61.00         Total anount payable bad debts (see instructions)         5.678.44.62.6           62.00         Colinsurance billed to program beneficiaries (line 59 minus line 60)         5.878.859	48.00		mall rural hospitals	0		48.00
49.00Total payment for inpatient operating costs (see instructions)1.0049.00Total payment for inpatient program capital (from Wkst. L, Pt. 1 and Pt. 11, as applicable)5,476,18149.051.00Exception payment for inpatient program capital (Wkst. L, Pt. 11), see instructions).5,476,18149.052.00Direct graduate medical education payment (from Wkst. E. 4, line 49 see instructions).0.51.052.053.00Nursing and Allied Health Managed Care payment0.52.00.52.00.52.054.01Islet isolation add-on payments for new technologies0.54.055.055.01Cellular therapy acquisition cost (see instructions)0.55.055.056.00Notrine service other pass through costs from Wkst. D, Pt. 111, column 9, lines 30 through 35).0.57.057.00Routine service other pass through costs from Wkst. D, Pt. 111, column 9, lines 30 through 35).0.58.060.00Primary payer payments0.56.061.00Total (sum of amounts on lines 49 through 58)0.65.062.00Deductibles billed to program beneficiaries (line 59 minus line 60)5.878,859 59.063.00Col insurance billed to program beneficiaries (see instructions)3.643,54464.00Al usable bad debts (see instructions)3.643,54465.00Nett reimbursable bad debts (see instructions)1.63566.00Al usable bad debts (see instructions)3.64967.00Subtotal (line 61 plus line 65 minus lines 62 and 63)5.438,00667.00Subtotal (line 61 plus line 65 minus lines 62 and 63)68.0					Amount	
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51.00Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)051.052.00Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).052.053.00Nursing and Allied Health Managed Care payment052.054.00Special add-on payments for new technologies054.054.01Islet isolation add-on payment054.055.01Cellular therapy acquisition cost (kest. D-4 Pt. III, col. 1, line 69)055.055.00Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)055.056.00Cost of physicians' services in a teaching hospital (see intructions)055.057.00Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)058.058.00Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)058.060.00Primary payer payments060.060.061.00Total amount payable for program beneficiaries (line 59 minus line 60)5, 897, 85961.062.00Deductibles billed to program beneficiaries443, 54462.063.00Coinsurance billed to program beneficiaries (see instructions)3, 64463.064.00Allowable bad debts (see instructions)3, 64165.065.00Adj usted reimbursable bad debts (see instructions)3, 64165.066.00Allowable bad debts for dual eligible beneficiaries (see instructions)5, 67864.067.00Su	49.00	Total payment for inpatient operating costs (see instructions)	)			49.00
52.00Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).52.053.00Nursing and Allied Health Managed Care payment054.00Special addo-on payments for new technologies054.01Islet isolation add-on payment055.00Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)056.00Cost of physicians' services in a teaching hospital (see intructions)057.00Routine service other pass through costs (from Wkst. D, Pt. III, col. 11 line 200)058.00Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)059.00Total (sum of amounts on lines 49 through 58)060.00Primary payer payments061.00Total (sum of program beneficiaries163.00Adjusted reinbursable bad debts (see instructions)5,897,85964.00Allowable bad debts for dual eligible beneficiaries (see instructions)5,68765.00Adjusted reinbursable bad debts (see instructions)3,69165.00Adjusted reinbursable bad debts (see instructions)3,69165.00Adjusted reinbursable bad debts (see instructions)5,438,00666.00Allowable bad debts for dual eligible beneficiaries (see instructions)5,438,00667.00Subtotal (line 61 plus line 65 minus line 63)5,438,00668.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)069.00Ottiler payment adjustment amount (see instructions)0	50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)		421, 678	50.00
53.00Nursing and Allied Health Managed Care payment053.054.00Special add-on payments for new technologies054.055.01Cellular therapy acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)054.055.01Cellular therapy acquisition cost (see instructions)055.056.00Cost of physicians' services in a teaching hospital (see intructions)055.057.00Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)056.059.00Total (sum of amounts on lines 49 through 58)056.060.00Primary payer payments058.061.00Total amount payable for program beneficiaries (line 59 minus line 60)5,897,85959.062.00Deductibles billed to program beneficiaries063.063.00Colnsurance billed to program beneficiaries063.064.00Allowable bad debts (see instructions)5,678 64.064.065.00Subtatal (line 61 plus line 65 minus lines 62 and 63)5,678 64.064.066.00Subtatal (line 61 plus line 65 minus lines 62 and 63)5,678 64.064.067.00Subtatal (line 61 plus line 65 minus lines 62 and 63)5,678 64.064.067.00Subtatal (line 61 plus line 65 minus lines 62 and 63)5,678 64.067.068.00Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)066.069.00Duttier payment adjustment amount (see instructions)070.0 <td< td=""><td>51.00</td><td>Exception payment for inpatient program capital (Wkst. L, Pt.</td><td><pre>III, see instructions)</pre></td><td></td><td>0</td><td>51.00</td></td<>	51.00	Exception payment for inpatient program capital (Wkst. L, Pt.	<pre>III, see instructions)</pre>		0	51.00
54.00Special add-on payments for new technologies054.054.01Islet isolation add-on payment054.055.00Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)055.055.01Cellular therapy acquisition cost (see instructions)055.056.00Cost of physicians' services in a teaching hospital (see intructions)056.0057.00Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)056.0059.00Total (sum of amounts on lines 49 through 58)5.897,85959.060.00Primary payer payments5.897,85961.0062.0061.00Total amount payable for program beneficiaries (line 59 minus line 60)5.67864.062.00Deductibles billed to program beneficiaries463,54462.0063.00Coinsurance billed to program beneficiaries66.0063.0064.00Allowable bad debts (see instructions)5.67864.065.00Adjusted reimbursable bad debts (see instructions)3.69165.0066.00Allowable bad debts for dual eligible beneficiaries (see instructions)3.69165.0067.00Ottler payments recordilation (sum of lines 93, 95 and 96). (For SCH see instructions)068.0068.00Credit sreceived from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)068.0070.00Ottler payments recordilation (sum of lines 93, 95 and 96). (For SCH see instructions)070.0070.70N5 respirator payment	52.00	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		0	52.00
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70. 93HVBP payment adjustment amount (see instructions)070. 970. 94HRR adjustment amount (see instructions)070. 9					-	70. 91
70.94       HRR adjustment amount (see instructions)       0       70.9						70. 92
						70.93
70. Yo recovery of accelerated depreciation 0 / 70. Yo		<b>3</b>				
	10. 95				0	1 10. 95

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/31/2023 9:1	
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	′ (yyyy)	Amount	
				0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column O		0	0	70.9
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70.9
	the corresponding federal year for the period ending on or after			0	0	/0. /
	Low Volume Payment-3				0	70.9
0.99	HAC adjustment amount (see instructions)				0	70.9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 64	9 & 70)			5, 438, 006	71.0
	Sequestration adjustment (see instructions)				68, 519	
	Demonstration payment adjustment amount after sequestration				0	71.0
	Sequestration adjustment-PARHM or CHART pass-throughs					71.0
	Interim payments Interim payments PAPHW or CHAPT				5, 365, 491	72.0
	Interim payments-PARHM or CHART Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM or CHART (for contractor use only)				0	73.0
	Balance due provider/program (line 71 minus lines 71.01, 71.02,	. 72. and			3, 996	
	73)					
74.01	Balance due provider/program-PARHM or CHART (see instructions)					74.0
	Protested amounts (nonallowable cost report items) in accordance	ce with			512, 552	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
90.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum o	£ 2.02			0	90.0
	plus 2.04 (see instructions)	1 2.03			0	90.0
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
	Operating outlier reconciliation adjustment amount (see instruct	ctions)			0	92.0
	Capital outlier reconciliation adjustment amount (see instructi				0	93.0
94.00	The rate used to calculate the time value of money (see instruct	ctions)			0.00	
	Time value of money for operating expenses (see instructions)				0	95.0
96.00	Time value of money for capital related expenses (see instruction	ions)		D: 10/1	0	96.0
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	-
	HSP bonus amount (see instructions)			0	0	100. 0
	HVBP Adjustment for HSP Bonus Payment					1
01.00	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	101. 0
	HVBP adjustment amount for HSP bonus payment (see instructions)	)		0	0	102.0
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	
	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adiu	stmont	0	0	104.0
	Is this the first year of the current 5-year demonstration peri					200. 0
.00.00	Century Cures Act? Enter "Y" for yes or "N" for no.		10 2131			200.0
	Cost Reimbursement					1
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201.0
	Medicare discharges (see instructions)					202.0
	Case-mix adjustment factor (see instructions)	<u> </u>	6.11			203. 0
	Computation of Demonstration Target Amount Limitation (N/A in 1	rirst year	or the curre	nt 5-year demonst	ration	
	period) Medicare target amount					204. 0
	Case-mix adjusted target amount (line 203 times line 204)					205.0
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 0
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see instru					207.0
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I	line 59)				208.0
	Adjustment to Medicare IPPS payments (see instructions)					209.0
	Reserved for future use					210. C
	Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement					211. C
	Total adjustment to Medicare Part A IPPS payments (from line 2)	11)				212.0
	3					213.0
13.001	00 Low-volume adjustment (see instructions)					218. C
	Net Medicare Part A IPPS adjustment (difference between PPS and					

	Financial Systems LUTHERAN MUSCULOSKE			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/31/2023 9:1 PPS	<u>3 am</u>
		Intre XVIII	nospital	FF3	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			258	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		7, 820, 715	
3.00	OPPS payments			8, 643, 636	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			3, 420 0	
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			258	11.00
	Reasonable charges				
12.00	Ancillary service charges				12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	ine 69)		0 5, 521	13.00 14.00
14.00	Customary charges			5, 521	14.00
15.00	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable fo		n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17.00
18.00	Total customary charges (see instructions)			5, 521	18.00
19.00	Excess of customary charges over reasonable cost (complete on instructions)	ly if line 18 exceeds li	ne 11) (see	5, 263	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions)			258	21.00
21.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			258	
23.00	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)			8, 647, 056	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	s)		10, 146	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	-	uctions)	1, 302, 755	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	7, 334, 413	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			7, 334, 413	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 627 7, 332, 786	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
34.00	Adjusted reimbursable bad debts (see instructions)			21, 124 13, 731	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		22, 436	36.00
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			7, 346, 517 0	
38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39.75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	-
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			7, 346, 517	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			92, 566 0	
40.03	Sequestration adjustment-PARHM or CHART pass-throughs			-	40.03
41.00	Interim payments			7, 235, 624	
41. 01 42. 00	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)			Ū	42.01
43.00	Balance due provider/program (see instructions)			18, 327	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	chapter 1	0	43.01 44.00
11.00	§115. 2				11.00
00.00	TO BE COMPLETED BY CONTRACTOR			0	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74.00	Total (Suil OF THES 71 dilu 73)			0	1 74.00

Health Financial Systems	LUTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0168	Peri od:	Worksheet E	
		From 01/01/2022		
		To 12/31/2022	Date/Time Pre	
			5/31/2023 9:1	<u>3 am</u>
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part I Date/Time Prep 5/31/2023 9:13	pared:
		Title	XVIII	Hospi tal	PPS	_
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5, 365, 49	1	7, 235, 624	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
2 50	Provider to Program			0	0	2 50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.51
3.51				0	0	3.52
3.52				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)		5, 365, 49	1	7, 235, 624	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program			-	-	
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5.92 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
J. 77	5. 50-5. 98)			0	0	J. 75
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		3, 99	6	18, 327	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		5, 369, 48		7, 253, 951	7.00
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
			1			

Heal th	Financial Systems LUTHERAN MUSCUL	LOSKELETAL CENTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0168	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 9:	epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT	S			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA	TION			
1.00	Total hospital discharges as defined in AARA §4102 from W	/kst. S-3, Pt. I col. 15 line	e 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 20	00			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	is)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestrat	ion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instruction	ns)		32.00

	Financial Systems LUTHERAN MUSCULOS ATION OF REIMBURSEMENT SETTLEMENT	KELETAL CENTER Provider CCN: 15-0168	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2022	Part VII	
			To 12/31/2022	Date/Time Pre 5/31/2023 9:1	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S COMPUTATION OF NET COST OF COVERED SERVICES	SERVICES FOR TITLES V OR 7	IX SERVICES		-
. 00	Inpatient hospital/SNF/NF services		582, 330		1.00
2.00	Medical and other services			242, 629	2.00
. 00	Organ acquisition (certified transplant programs only)		0		3.0
. 00	Subtotal (sum of lines 1, 2 and 3)		582, 330	242, 629	
5.00 5.00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5.0 6.0
7.00	Subtotal (line 4 less sum of lines 5 and 6)		582, 330	242, 629	1
	COMPUTATION OF LESSER OF COST OR CHARGES		,	,	
	Reasonabl e Charges				
3.00	Routine service charges		0		8.00
. 00	Ancillary service charges		1, 204, 219	3, 048, 714	
0.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.0
	Total reasonable charges (sum of lines 8 through 11)		1, 204, 219	3, 048, 714	1
	CUSTOMARY CHARGES		.,,		1
3.00	Amount actually collected from patients liable for payment a	for services on a charge	0	0	13.0
	basi s				
4.00	Amounts that would have been realized from patients liable t a charge basis had such payment been made in accordance with		on O	0	14.0
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	11 42 CFR 9413: 13(e)	0. 000000	0. 000000	15.0
	Total customary charges (see instructions)		1, 204, 219	3, 048, 714	
7.00	Excess of customary charges over reasonable cost (complete o	only if line 16 exceeds	621, 889	2, 806, 085	
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete of	only if line 4 exceeds lin	ne 0	0	18.0
9.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.0
	Cost of physicians' services in a teaching hospital (see ins	structions)	0	0	20.0
	Cost of covered services (enter the lesser of line 4 or line		582, 330	242, 629	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b	be completed for PPS provi	ders.		
	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
	Program capital payments Capital exception payments (see instructions)		0		24.0 25.0
	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	1
28.00	Customary charges (title V or XIX PPS covered services only)	)	0	0	28.0
9.00	Titles V or XIX (sum of lines 21 and 27)		582, 330	242, 629	29.0
0.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 20 0
30.00 31.00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	6)	582, 330	0 242, 629	
32.00	Deductibles	0)	0	242,029	
	Coinsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0		35.0
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	and 33)	582, 330		
7.00	ZERO OUT SETTLEMENT		-582, 330		
38.00 39.00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	0	38.0 39.0
	Total amount payable to the provider (sum of lines 38 and 39	9)	0	0	
1.00	Interim payments	<i>,</i>	0	0	1
	Interim payments Balance due provider/program (line 40 minus line 41)		0	0	
2.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		-		

Health Financial Systems	UTHERAN MUSCULOSKELETAL CENTER	In Lie	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0168	Period: From 01/01/2022	Worksheet E-5	
		To 12/31/2022	Date/Time Prep 5/31/2023 9:13	
	Title XVIII		PPS	
			1.00	
TO BE COMPLETED BY CONTRACTOR				
1.00 Operating outlier amount from Wkst. E, Pt. A	A, line 2, or sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment	amount (see instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment an	nount (see instructions)		0	4.00
5.00 The rate used to calculate the time value of	f money (see instructions)		0.00	5.00
6.00 Time value of money for operating expenses (	(see instructions)		0	6.00
7.00 Time value of money for capital related expe			0	7.00

	Financial Systems LUTHERAN MUSCULOS E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0168	Period: From 01/01/2022	u of Form CMS-2 Worksheet G	
ly)	ype accounting records, comprete the deneral rund cordinin			To 12/31/2022	Date/Time Pre 5/31/2023 9:1	pare 3 am
		General Fund	Specific Purpose Fund			
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-736, 760		0 0	0	1 1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0	I I	0 0	0	3
00	Accounts receivable	35, 699, 068		0 0	0	4
00	Other receivable	0		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-5, 157, 270		0 0	0	
00	Inventory	3, 270, 426		0 0	0	
00	Prepai d expenses	339, 834		0 0	0	8
00 . 00	Other current assets	65, 285		0 0	0	10
	Due from other funds Total current assets (sum of lines 1-10)	33, 480, 583		0 0		10
. 00	FIXED ASSETS	33, 460, 363	1	0 0	0	1''
. 00	Land	0		0 0	0	1 12
. 00	Land improvements	26, 765		0 0		
	Accumulated depreciation	-19, 271		0 0	0	14
. 00	Buildings	129, 797		0 0	0	15
. 00	Accumulated depreciation	-20, 375		0 0	0	16
. 00	Leasehold improvements	4, 624, 017		0 0	0	17
. 00	Accumulated depreciation	-1, 839, 382		0 0	0	18
	Fixed equipment	2, 358, 651	1	0 0	0	19
	Accumulated depreciation	-693, 723		0 0	0	20
	Automobiles and trucks	28, 303		0 0	0	21
	Accumulated depreciation	-28, 303		0 0	0	22
	Major movable equipment	17, 332, 676		0 0	0	23
	Accumulated depreciation	-11, 194, 524		0 0	0	24
	Minor equipment depreciable Accumulated depreciation	3, 630, 061 -2, 524, 181		0 0	0	25
	HIT designated Assets	-2, 524, 161		0 0	0	27
	Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0		
	Total fixed assets (sum of lines 12-29)	11, 810, 511		0 0		
	OTHER ASSETS		,			1
. 00	Investments	0	r	0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	19, 333, 634	1	0 0	0	34
	Total other assets (sum of lines 31-34)	19, 333, 634		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	64, 624, 728		0 0	0	36
	CURRENT_LIABILITIES	( 000 000	1			
	Accounts payable	6, 228, 083	1	0 0		37
	Salaries, wages, and fees payable Payroll taxes payable	2, 608, 195		0 0	0	
	Notes and Loans payable (short term)	229, 909 2, 198, 593		0 0	0	
	Deferred income	2, 190, 393		0 0	0	
	Accelerated payments	0		0	Ŭ	42
	Due to other funds	-435, 190, 648		0 0	0	
	Other current liabilities	1, 500, 059	1	0 0		
	Total current liabilities (sum of lines 37 thru 44)	-422, 425, 809		0 0		
	LONG TERM LIABILITIES					1
	Mortgage payable	0	1	0 0	0	46
. 00	Notes payable	15, 498, 532		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	48
	Other long term liabilities	51, 706, 917		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	67, 205, 449		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	-355, 220, 360		0 0	0	51
~ ~	CAPI TAL ACCOUNTS		1			1
	General fund balance	419, 845, 088			l	52
. 00	Specific purpose fund			0	l	53
. 00	Donor created - endowment fund balance - restricted			0	ł	54
. 00	Donor created - endowment fund balance - unrestricted			0	1	55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	50
. 00						
. 00	Total fund balances (sum of lines 52 thru 58)	419, 845, 088		0 0	0	59

		THERAN MUSCULOS			In Lie	u of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CCN: 15-0168		Period: From 01/01/2022 To 12/31/2022	Worksheet G-1 Date/Time Prepared 5/31/2023 9:13 am		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		2.30 376, 362, 454 43, 482, 634 419, 845, 088 0 419, 845, 088 0 419, 845, 088	5.00		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
1 00	Fund halanasa at hasing of pariod	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

ATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0168	Period: From 01/01/2022 To 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2023 9:1	epared	
	Cost Center Description		Inpati ent	Outpati ent	Total		
			1.00	2.00	3.00		
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
00	Hospi tal		8, 639, 6		8, 639, 690		
00	SUBPROVIDER - IPF			0	0		
00	SUBPROVIDER - IRF			0	0		
00	SUBPROVIDER					4.	
00	Swing bed - SNF			0	0		
00	Swing bed - NF			0	0	6.	
00	SKILLED NURSING FACILITY			0	0	7.	
00	NURSING FACILITY			0	0	8.	
00	OTHER LONG TERM CARE			0	0	9.	
. 00	Total general inpatient care services (sum of lines 1-9)		8, 639, 6	90	8, 639, 690	10.	
	Intensive Care Type Inpatient Hospital Services						
. 00	INTENSIVE CARE UNIT			0	0	11.	
. 00	CORONARY CARE UNIT			0	0	12	
. 00	BURN INTENSIVE CARE UNIT			0	0	13.	
. 00	SURGICAL INTENSIVE CARE UNIT			0	0	14	
. 00	OTHER SPECIAL CARE (SPECIFY)					15.	
. 00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.	
	11-15)						
. 00	Total inpatient routine care services (sum of lines 10 and 16)	)	8, 639, 6	90	8, 639, 690	17	
. 00	Ancillary services		287, 344, 7		931, 690, 292		
. 00	Outpatient services		576, 6		5, 872, 823		
. 00	RURAL HEALTH CLINIC			0 0	0		
. 00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0		
. 00	HOME HEALTH AGENCY			0	0		
. 00	AMBULANCE SERVICES			0 0	0	23.	
. 00	СМНС			0	0	24.	
. 10	CORF			0 0	0		
. 00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0		
. 00	HOSPICE			0 0	0		
. 00	OTHER (SPECIFY)			0 0	0		
. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	296, 561, 0	68 649, 641, 737	946, 202, 805		
	G-3, line 1)				,,		
	PART II - OPERATING EXPENSES						
. 00	Operating expenses (per Wkst. A, column 3, line 200)			126, 674, 456		29	
00	ADD (SPECIFY)			0		30	
. 00				0		31	
. 00				0		32	
. 00				0		33	
.00				0		34	
.00				0		35	
00	Total additions (sum of lines 30-35)			0		36	
00	DEDUCT (SPECIFY)			0		37	
00				0		38	
00				0		39	
. 00				0		40	
00				0		41	
. 00	Total deductions (sum of lines 37-41)			~ 		42	
00	Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfor		126, 674, 456		42	
. 00	to Wkst. G-3, line 4)			120, 074, 430		43	

Heal th	Financial Systems	LUTHERAN MUSCULOSK	ELETAL CENTER	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0168	Period: From 01/01/2022	Worksheet G-3	
				To 12/31/2022	Date/Time Pre	pared:
					5/31/2023 9:1	
1.00			202)		1.00	1 00
1.00	Total patient revenues (from Wkst.				946, 202, 805	1.00
2.00	Less contractual allowances and dis		nts		777, 328, 265	
3.00	Net patient revenues (line 1 minus		(2)		168, 874, 540	
4.00	Less total operating expenses (from		43)		126, 674, 456	
5.00	Net income from service to patients	(line 3 minus line 4)			42, 200, 084	5.00
6 00	OTHER INCOME	ata			0	6 00
6.00 7.00	Contributions, donations, bequests, Income from investments	etc			0	6.00 7.00
7.00 8.00	Revenues from telephone and other m	i cool l'apoque, communi cati or			0	7.00 8.00
8.00 9.00	Revenue from television and radio s		I Sel VI Ces		0	
9.00 10.00	Purchase di scounts	ervice			0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
12.00	Revenue from Laundry and Linen serv	i co			0	13.00
14.00	Revenue from meals sold to employee				0	14.00
	Revenue from rental of living quart				0	15.00
16.00	Revenue from sale of medical and su		than natients		0	16.00
17.00	Revenue from sale of drugs to other		than patronto		0	17.00
18.00	Revenue from sale of medical record				0	18.00
19.00	Tuition (fees, sale of textbooks, u				Ő	19.00
20.00	Revenue from gifts, flowers, coffee				Ő	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 I NCOME				1, 282, 550	
24.50	COVID-19 PHE Funding				0	24.50
	Total other income (sum of lines 6-	24)			1, 282, 550	
	Total (line 5 plus line 25)	-			43, 482, 634	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 2	7 and subscripts)			0	28.00
29 00	Net income (or loss) for the period	(line 26 minus line 28)			43, 482, 634	29.00

	Financial Systems LUTHERAN MUSCULO ATION OF CAPITAL PAYMENT	Provider CCN: 15-0168	Peri od:	Worksheet L	
			From 01/01/2022	Parts I-III	
			To 12/31/2022		
		Title XVIII	Hospi tal	5/31/2023 9:13 PPS	3 811
			nospi tai	115	
			-	1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			416, 825	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			4, 853	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	reporting period (see inst	ructions)	10. 47	3.00
4.00	Number of interns & residents (see instructions)			0.00	4.00
5.00	Indirect medical education percentage (see instructions)			0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part # 30) (see instructions)		, part A line	0.00	7.0
3.00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8.00
9.00	Sum of lines 7 and 8			0.00	
	Allowable disproportionate share percentage (see instruction	ons)		0.00	
11.00				0	
12.00	Total prospective capital payments (see instructions)			421, 678	12.00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	1		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 circumsta	ances (see instructions)		0	2.0
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.0
4.00	Applicable exception percentage (see instructions)			0.00	4.0
5.00	Capital cost for comparison to payments (line 3 x line 4)	· + + ·		0	5.0
5.00	Percentage adjustment for extraordinary circumstances (see			0.00	6.0
7.00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 >	ciine 6)	0	7.0
3.00	Capital minimum payment level (line 5 plus line 7)			0	8.0
9.00	Current year capital payments (from Part I, line 12, as app		Loop Line ()	0	9.0
10.00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	10.00
11.00	Tear yover of accumulated capital minimum payment level over	capital payment (irom pri	or year	0	11.0

11.00	loan yover of accumulated capital minimum payment rever over capital payment (nom piror year	0	11.00
	Worksheet L, Part III, line 14)		
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period	0	14.00
	(if line 12 is negative, enter the amount on this line)		
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00